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ABSTRACT

This manual describes in detail the Developmental Evaluation Services for Children program (DESC), a model interdisciplinary project funded to help others implement similar diagnostic and treatment services for young children with developmental difficulties. Section 1 gives an overview of the DESC project and describes the evaluation process in detail. Criteria for referral and acceptance complete this section. Section 2 describes the assessment process and the diagnostic nursery. In addition, two charts depict the assessment procedures: one summarizes the basic diagnostic questions addressed by each discipline; the other summarizes procedures used by each discipline. Sections 3 and 4 describe the administrative and professional responsibilities and functions in the DESC model. Section 5 suggests alternatives for staffing a DESC-type program which, while preserving the basic concept, requires less staff. (Author/MP)

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REPLICATION MANUAL

DEVELOPMENTAL EVALUATION SERVICES FOR CHILDREN

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ROCKVILLE, MARYLAND 20852

MONTGOMERY COUNTY HEALTH DEPARTMENT
MONTGOMERY COUNTY PUBLIC SCHOOLS

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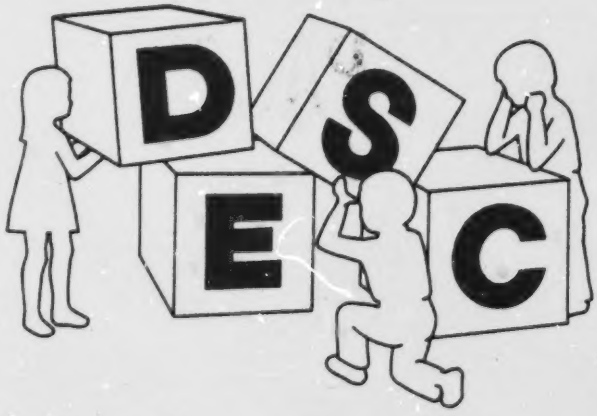

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DEVELOPMENTAL EVALUATION SERVICES FOR CHILDREN

REPLICATION MANUAL

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BACKGROUND

It is well known that there are many diagnostic services and treatment programs for children who need such efforts. Unfortunately, few of these resources combine the multiple diagnostic efforts through an interdisciplinary, interagency approach for children with developmental difficulties. This document is a "how to" manual which describes in detail how one model program can be copied or modified in other communities. This manual was prepared by Montgomery County Public Schools and Montgomery County Health Department with professionals preparing their own unique approaches.

INTRODUCTION

Developmental Evaluation Services for Children (DESC) is a model project funded to help others implement similar services. Thorough interdisciplinary assessment of young children's developmental difficulties, completed in a short period of time, constitutes a major service component of DESC. The DESC staff has compiled this manual to show the assessment process in depth.

Section I, Project Overview, introduces the DESC project in general and gives an overall view of the Evaluation Process from start to finish. A flow chart graphically represents the process. Criteria for referral and acceptance completes this section.

Section II describes the assessment process and the diagnostic nursery. In addition, two charts depict the assessment procedures. One summarizes the basic diagnostic questions addressed by each discipline and the other summarizes the procedures used by each discipline.

Sections III and IV describe the administrative and professional responsibilities and functions in the DESC model. Section V suggests alternatives for staffing a DESC-type program which, while preserving the basic concept, require less staff.

SECTION I: PROJECT OVERVIEW

Preface

Section I introduces the project in general and gives an overall view of the evaluation process. A flow chart representing the process and the selection criteria are included.

DESC: THE EVALUATION PROCESS

DESC disseminates information about the program to area professionals, agencies, and organizations who serve children. They, in turn, refer parents of children with handicaps or suspected disabilities which might impede progress through school.

Parents call DESC and describe the conditions they or others have observed in their children. The nurse coordinator solicits information from parents and school and health care providers to determine if DESC services are appropriate for the child. If DESC evaluation is appropriate, based on established criteria, the child is accepted for evaluation. If not, the family is counseled about what services might be indicated and referred to the service agency that can meet its needs. If the nurse coordinator feels that the referral needs to be considered for acceptance/nonacceptance by the DESC professional staff, the case is brought to a staff intake conference for a decision.

Once the child is accepted, appointments are made for evaluations by the audiologist, educational diagnostician, pediatrician, psychiatric social worker, psychologist, speech pathologist, and others as needed. These evaluations usually are scheduled in 3 to 4 visits over a 3-week period.

After the evaluations are completed, the DESC team holds a preconference to discuss evaluation results, possible remediation, and placement recommendations. Other involved professionals who know the child are invited to the team conference.

A parent conference is then held to relate the findings and make recommendations to the parents. An Educational Management Plan is prepared as a basis for the more specific Individual Educational Plan (IEP) drawn up later by the educational program the child enters.

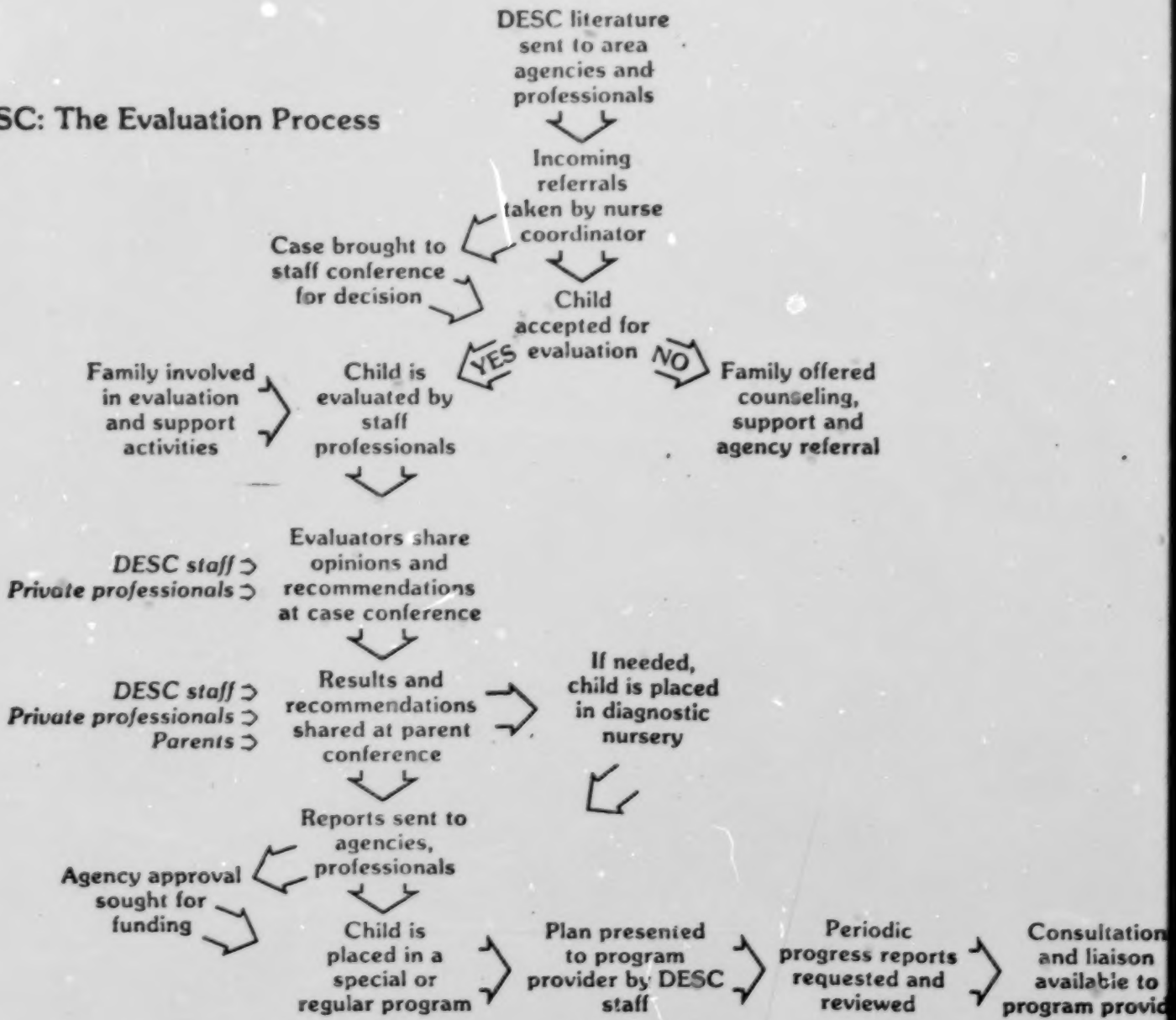
A Conference Summary is sent to parents, private professionals, and involved program operators. If special placement is recommended by the team and accepted by the parents, the report is also sent to the Montgomery County Public Schools'(MCPS) Placement Office for approval for funding the placement in any one of the following special programs: Easter Seal Treatment Center, MCARC Preschool (Montgomery County Association for Retarded Citizens), Christ Church Child Center, Centers for the Handicapped, or MCPS special classes (e.g., noncategorical preschool class, Headstart Learning Center, self-contained language class or an elementary learning center) or

others. If the child does not need a special placement, he may attend a nursery or day care center. In either case a representative of the team visits the school to interpret the Educational Management Plan to the teacher if indicated. DESC also offers four counseling sessions to parents to help with child management and adjustment to the child's handicap.

A diagnostic nursery is available for observation of a child's behavior in a familiar, nontesting situation 2½ hours, three times a week for 4-6 weeks. Children may come to the nursery before acceptance to determine their need for a complete evaluation. They may enter the nursery after evaluation for a longer look at their behavior, learning styles, and general program needs.

An initial (3 months after placement) and a year-end progress report are requested and reviewed by DESC staff. Continuing consultation is available if the child is not progressing during the preschool years.

DESC: The Evaluation Process


DESC literature sent to area agencies and professionals
Incoming referrals taken by nurse coordinator
Case brought to staff conference for decision
Child accepted for evaluation
YES
NO
Family offered counseling, support and agency referral
Family involved in evaluation and support activities
Child is evaluated by staff professionals
DESC staff
Private professionals
Evaluators share opinions and recommendations at case conference
DESC staff
Private professionals
Parents
Results and recommendations shared at parent conference
If needed, child is placed in diagnostic nursery
Reports sent to agencies, professionals
Agency approval sought for funding
Child is placed in a special or regular program
Plan presented to program provider by DESC staff
Periodic progress reports requested and reviewed
Consultation and liaison available to program provid

CRITERIA FOR ACCEPTANCE

A. Basic Requirements:

1. Montgomery County resident, 0-5 years, with difficulties in <u>two</u> or more of the following areas:

   -Gross motor skills
   -Fine motor skills
   -Communication skills (hearing, language and speech)
   -Cognitive/intellectual skills
   -Social-adaptive (behavioral) skills, except hyperactivity
   -Chronic medical problem(s)

2. Child up to age 9.0, new to the county, with an evident problem in two or more of the above areas but without adequate information or established address and needs an evaluation for placement.

B. Special Considerations:

1. A hyperactive child (social-adaptive area) must <u>also have delays in two other areas</u> (e.g. social-adaptive + fine motor + gross motor).

2. A child who is making inadequate progress in a preschool program must have utilized the evaluative resources of that respective program before being referred to DESC.

3. A Protective Services case with developmental delays will be accepted through Montgomery County Health Department area physicians rather than directly from Department of Social Services.

4. A foster child with developmental delays who has been in placement <u>at least 4 months</u> will be accepted directly from the Department of Social Services' worker or foster parent.

SECTION II: GENERAL ASSESSMENT PROCESS

Preface

Section II focuses on those evaluation activities directly involved in the assessment of the child. The overall child assessment process is first described and then summarized in a flow chart.

The Diagnostic Nursery is described. An Assessment Matrix listing each evaluator's concerns follows. These Procedures and Instruments are summarized in the Instrument Tables.

ASSESSMENT PROCESS

In the DESC evaluation process, activities may be classified as being preassessment, assessment, and postassessment.

PREASSESSMENT: Preassessment services include the nurse coordinator obtaining the case history and appointing a case manager to guide the parents and child through the process. An appointment schedule and transportation arrangements are established at this time.

ASSESSMENT: Assessment activities usually involve three to five clinic visits over a period of two to three weeks. Age level assessments are:

0-12 months: audiologic, Denver Developmental Screening Test* (DDST), educational diagnostic developmental, pediatric and social work

13-24 months: audiologic, educational diagnostic developmental, pediatric and social work. In addition, a language-speech evaluation is done at ages 18-24 months.

25 months and over: Complete assessment - audiologic, educational diagnostic, language-speech, psychological and social work. Vision screening is performed at age 3 years and over.

In some cases a partial evaluation of at least two areas of development is scheduled when the staff feels a full evaluation would be repetitive or unnecessary.

FIRST VISIT: A preliminary work-up is performed which includes vision screening, body measurements, and laboratory tests. The pediatric history taking and examination immediately follows. The objective of this visit is to identify past or present medical problems that may limit the child, judge the relationship of these problems to the child's functioning, suggest methods of correcting or minimizing them, and look for genetic factors in developmental problems.

*The Denver results are compared to educational diagnostic results as a continuing study to determine if it alone will be sufficient under the age of 13 months.

SECOND VISIT: The audiologist evaluates the child's hearing and function of the entire hearing system in order to identify the extent and possibly the cause of any hearing loss that may be present and make an appropriate recommendation. This visit also includes a language and speech evaluation by the speech pathologist who tests the child's comprehension, use of verbal language, and ability to correctly articulate speech sounds. Voice quality, speech fluency, and oral-motor skills are also assessed.

THIRD VISIT: The psychiatric social worker first observes the family/child interaction and then interviews the family alone for a full assessment of the child's family system at that time. The child is seen by the psychologist for an evaluation of intellectual, developmental, and emotional functioning.

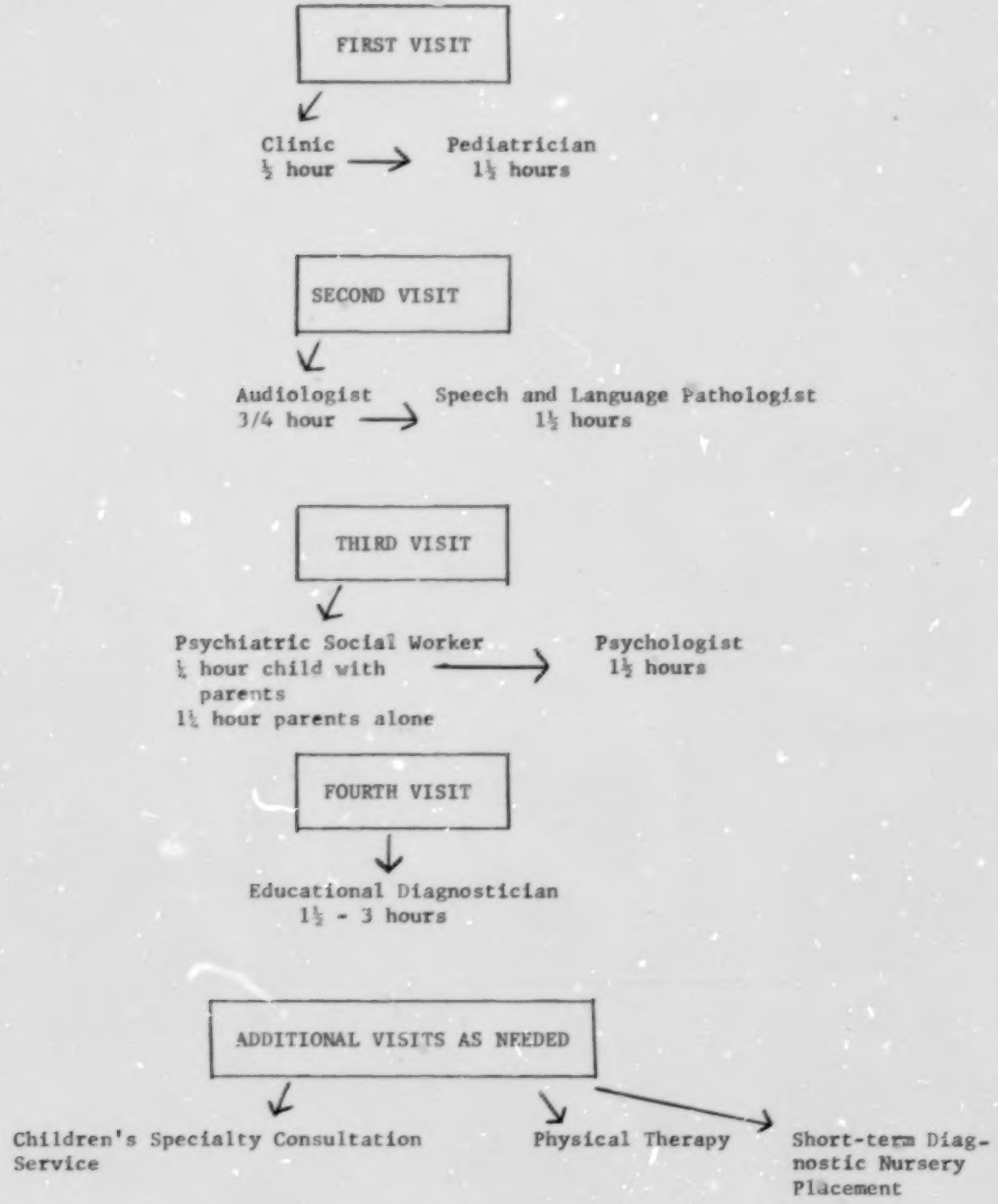
FOURTH VISIT: The educational diagnostician evaluates the child's comprehensive developmental profile, determining learning strengths, weaknesses, and significant delays. The parents may observe this assessment, which takes place in the Diagnostic Nursery, through a one-way mirror in an observation booth adjacent to the nursery. The parents are accompanied by another educational diagnostician who interprets the activities and interviews the family as part of the assessment.

ADDITIONAL VISITS: Additional visits may be scheduled as needed. These may involve short-term (4-6 week) placement in the Diagnostic Nursery for further observation, evaluation by the physical therapist, and/or visits to the Montgomery County Health Department Children's Specialty Consultation Service for evaluations in such specialized fields as allergy; ear, nose and throat; neurology; orthopedics; ophthalmology; cardiology; etc.

NOTE: A flow sheet is kept during the evaluation. Examiners informally summarize the findings and list questions they would like other examiners to answer.

POSTASSESSMENT: Postassessment activities include the team preconference and a parent conference. At the preconference, the professionals who evaluated the child discuss their findings with each other. Other professionals who know the child are invited to share their observations. A profile of the child's strengths and weaknesses, a diagnostic impression, and preliminary recommendations are drawn up. The parents meet with the case manager and specific DESC evaluators whose findings are significant. Impressions and recommendations are discussed. Recommendations may include an educational placement by description but not by name, special tutoring or therapy, continued counseling, further evaluations by medical specialists, specific child management techniques, special recreational programs, etc. An Educational Management Plan is developed to provide a basis for the specific Individual Educational Plan (IEP) to be completed later by the educational program the child enters. Any further services directed toward appropriate diagnosis and placement of the child are as described in the Evaluation Process.

FLOW CHART: THE CHILD'S ASSESSMENT



DIAGNOSTIC NURSERY

The primary objective of the program is diagnostic. Activities are presented in order to observe the child's response to structure and to establish a base from which to predict behaviors. An approach is developed which works best with a child to both alleviate inappropriate behaviors and to intervene before these behaviors appear.

Not all children seen in DESC are placed in the Diagnostic Nursery. Those who are placed are children who exhibit an inconsistent pattern of behavior, those who need the benefit of a familiar setting, and those for whom the team needs a longer observation period for an adequate assessment. The nursery further serves as a place for screening those children who may or may not need complete evaluations. It provides a setting for developing strategies which best meet the child's needs and which work best in facilitating his learning. Children may be placed in the nursery for a period of 4-6 weeks; they attend 3 consecutive times a week for a period of 2½ hours each morning.

The diagnostic nursery classroom incorporates a one-way observation booth and intercom system and is a multifunctional, integral part of the project. This setting provides an excellent opportunity for parents to see their child's strengths and weaknesses and to learn management and teaching techniques by direct example. It affords the staff the opportunity to assist the unknowing or denying parent in coming to a realization of the problem. The team gives appropriate parental counseling in coping with the emotionally traumatic hurdles of that realization and concurrently reinforces the importance of early intervention.

The nursery also allows the staff to observe: a child's response to stimulation and to a structured setting; the hyperactive child's reaction to limit setting, structure, and possibly a trial on medication (monitored by the team pediatrician); and the child's inconsistent behaviors once he becomes familiar with and comfortable in an environment.

The classroom environment allows for extensive behavioral observations of the functioning of the total child. Within this evaluation, the family becomes involved to a great extent with considerable interaction between parent and professional. The many factors affecting a child's life can be identified and worked with in order to lead towards a fuller understanding of the child.

ASSESSMENT MATRIX

Introduction to Chart

The matrix on the following page lists the general questions individual professionals have in mind when they evaluate a patient. In the top horizontal boxes, the general approach of each evaluator is indicated. In the following six boxes are more specific questions each professional addresses in each of the six developmental areas. In developing this matrix, areas of overlap were eliminated as best possible. Although occasionally the same question may be asked of a parent or the same task required of a child more than once, the information gained answers different concerns for different professionals.

The numerical rankings are in the lower right hand corner of each box. For example, since general health is the pediatrician's primary emphasis, the number "1" is in the lower right hand corner of the general health box. The areas of gross and fine motor deserved the next most attention. Since they would have occupied the second and third spots, the numbers were averaged to give both fine and gross motor an importance rating of 2.5 which appears in the lower right hand corner of the gross motor and fine motor box.

ASSESSMENT MATRIX — DEVELOPMENTAL EVALUATION SERVICES FOR CHILDREN

	NURSE	PEDIATRICIAN	AUDIOLOGIST	SPEECH & LANGUAGE PATHOLOGIST	PSYCHIATRIC SOCIAL WORKER	PSYCHOLOGIST	EDUCATIONAL DIAGNOSTICIAN
GENERAL QUESTIONS	Is the child eligible? What are parent's and referrant's concerns? Does the child need the complete/partial evaluation as defined by intake orientation?	Are there physical and/or medical problems that interfere with child's optimal functioning?	Can the child perceive auditory stimuli?	Can the child process language?	How does the functioning of the family system affect the child's presenting problem(s) and remediability?	What are reasonable expectations for this child? Are there emotional factors that are significantly contributing to child's current functioning?	What is child's overall learning style? What are reasonable educational expectations for this child?
GENERAL HEALTH	What is the health history and current health status of the child and family? 1	What are the developmental and etiological factors in the general health picture? What remediation is possible? Genetic implications? Immediate medical crises affecting testability? 1	Any physical signs that relate to possible/probable problems in the auditory system? 2	Any health problems that could affect the child's ability to communicate? 5.5	If a general health problem exists, is the family aware? 4	Are there any physical limits on child's "testability"? 5	Are there any physical limitations on child's learning style and "testability"? 6
PERCEPTUO-COGNITIVE	What are the perceptuo-cognitive developmental milestones and current functioning? 4.5	Is there evidence of neurological malfunction? Is it medically remediable? What are the genetic implications? 4.5	Does the child perceive fine differences in sound? Can the child understand (at least) non-verbal communications? 3	Can the child understand what is presented? 2	What are the family perceptions and expectations of the child's general intellectual sensory abilities? 4	What are child's general intellectual abilities in relation to standardized norms? 1	What are the visual/cognitive strengths and deficits that affect child's learning process? 1
GROSS MOTOR	What are gross motor developmental milestones and current functioning? 4.5	Is there evidence of neurological malfunction? Is it medically remediable? What are the genetic implications? 2.5	Are there any apparent balance problems that would signal inner ear/neural dysfunction? 5	Any signs of significant deviations that would signal possible speech deficiencies? 4	What are the family perceptions and expectations of the child's general intellectual sensory abilities? 4	Are there any gross motor deficits that interfere with cognitive development and functioning? 6	What are the gross motor strengths and weaknesses that affect child's learning process? 4
FINE MOTOR	What are the fine motor developmental milestones and current functioning? 4.5	Is there evidence of neurological malfunction? Is it medically remediable? What are the genetic implications? 2.5	Can the child handle apparatus such as a hearing aid, if needed? 6	Any dysfunctions which affect speech production? 3	What are the family perceptions and expectations of the child's general intellectual sensory abilities? 4	Are there any apparent fine motor deficits that interfere with cognitive development and functioning? 4	What are the fine motor strengths and weaknesses that affect child's learning process? 2
HEARING LANGUAGE SPEECH	What are the hearing, language, and speech developmental milestones and current functioning? 4.5	Is there evidence of neurological malfunction? Is it medically remediable? What are the genetic implications? 4.5	What is nature and extent of hearing loss? What is cause of loss and type of remediation as related to prevention (e.g. genetic counseling)? 1	What is the child's total speech and language status? 1	What are the family perceptions and expectations of the child's general intellectual sensory abilities? 4	Are there hearing/language/speech factors that affect general intellectual functioning? 3	Are child's hearing/language speech modalities adequate for testing and academic program placement? 4
PERSONAL/SOCIAL ADAPTIVE	How do the child's peer and familial interactions relate to the presenting problem(s)? 2	What is the family disposition to medical interventions? What are the medical implications of the child/family interactions? 6	Can the parents and child carry out recommendations? 4	Are there any social/emotional factors that interfere with communication? 5.5	What methods has the family unit developed to interact with the child and perceived or real problems? 1	How does child's social-emotional development compare to age appropriate expectations? Are there indicators that significant emotional overlays limit current intellectual functioning? 2	Has child developed behavioral skills to function in stimulating classroom situation? 4

Each area numerically ranked according to emphasis by each staff member

TESTS USED UNDER 6 YEARS (FUNCTIONAL LEVEL)

	NURSE	PEDIATRICIAN	AUDIOLOGIST	SPEECH AND LANGUAGE PATHOLOGIST	PSYCHIATRIC SOCIAL WORKER	PSYCHOLOGIST	EDUCATIONAL DIAGNOSTICIAN
General Health	Core History & observation	General pediatric history & physical with vision screening & lab tests as indicated	observation	observation	Social service history and observation	observation	observation
Perceptuo-Cognitive	Core History Denver Developmental & observation	Pediatric History, Neurological	observation	Boehm Cognitive skills assessment battery (3-5) if delay found in language area	Same as general health	*Cattel (under 2) Binet (from 2-5) WPPSI (if over 4, no suspected delays WISC-R or WISC-(interchangeable) 5+) Leiter (deaf or foreign language speaking)	*Infant Learning Accomplishment Profile ILAP (under 2) & Learning Accomplishment Profile (LAP) (2-5) (if questions after Memphis) Memphis Developmental Checklist (MDC) (over 2) Boehm Test of Basic Concepts (kindergarten level) optional
Gross Motor	Same as perceptuo cognitive	Same as perceptuo-cognitive	observation	observation	Same as general health	observation	Infant LAP (under 2) MDC (over 2)
Fine Motor	Same as perceptuo cognitive	Same as perceptuo-cognitive	observation	observation	Same as general health	Same as perceptuo cognitive	Same as gross motor
Hearing, Language & Speech	Same as perceptuo cognitive	Same as perceptuo-cognitive	See next page	See next page	Same as general health	Same as perceptuo cognitive If Leiter given then observation in this area	Same as gross motor
Personal/ Social Adaptive	Same as perceptuo cognitive	Same as perceptuo-cognitive	observation	observation	Social work assessment	Observation, play therapy techniques	Infant LAP (under 2) MDC (over 2) and observation

*Cattel and LAP have similar tests. The LAP allows flexibility and tests learning "style" as well as accomplishment level. The Cattell gives a standard level of function and is seldom necessary under 2.

HEARING, LANGUAGE AND SPEECH TEST (UNDER 6)

Hearing	Air and Bone Conduction: tests are done according to age and response Downs and Northern Audiometric Assessment (birth - 2 years) Visual Reinforcement Audiometry (2 - 3 years) Tangible Reinforcement Audiometry Hugheson - Westlake Air Conduction Pure Tone Test Hugheson - Westlake Bone Conduction Pure Tone Test Speech Reception Threshold: (3 months +) Haskins Word Discrimination Test (basic test) (2½+) CID and Utley Speech Reception Tests (4+) Ross and Lerman Word Intelligibility by Picture Identification Impedence Test Battery For Children with Sensory-Neural Losses: Olson-Noffsinger Tone Decay Test, Rosenburg Modified Tone Decay Test, Carhart Tone Decay Test, Jerger and Jerger Suprathreshold Adaptation Test, Short Increment Sensitivity Index, Bekesy Test Battery, Jerger's Articulation Function ("Roll-over") Test Central Auditory Test Battery: Berlin Speech in Noise Test; Willeford Central Auditory Test Battery, Katz Shifting Spondaic Word Test
Language - Standard	Peabody Picture Vocabulary Test Carrow Test of Auditory Comprehension of Language Gesell Action Agent Test Oral Commissions Repeat of Digits and Sentences Spencer Memory for Sentences
Language - Optional	ITPA (for additional assessment of receptive and expressive language organizational abilities; includes auditory, visual, and vocal tasks) Bankson Language Screening Test (over 4 for further assessment of grammar, semantics, and auditory and visual perception) Receptive-Expressive Emergent Scale (0-3 yr. for specific expressive and receptive problems)
Speech - Standard	Oral Diadochokinetic Rate Goldman Fristoe Test of Articulation or Photo Articulation Test

TESTS USED OVER 6 YEARS (FUNCTIONAL LEVEL)

	NURSE	PEDIATRICIAN	AUDIOLOGIST	SPEECH & LANGUAGE PATHOLOGIST	PSYCHIATRIC SOCIAL WORKER	PSYCHOLOGIST	EDUCATIONAL DIAGNOSTICIAN
General Health	Core History & observation	Pediatric history & physical examination	observation	observation	Social work history and observation	observation	observation
Perceptuo-Cognitive	Core History Denver Developmental (DD) Screening Test observation	Pediatric history & neurological	observation	Peabody Picture Vocabulary Test	Same as general health	WISC or WISC-R Leiter (deaf or foreign language speaking children) Raven (usually correlates with school achievement so not used often)	Slingerland Silvarol's Classroom Reading Inventory Stanford Battery (if not done recently in school) Metropolitan Readiness Inventory (if question of readiness for first grade) Sound Blending (if specific reading problem)
Gross Motor	Same as perceptuo-cognitive	Same as perceptuo-cognitive	observation	observation	Same as general health	observation	observation
Fine Motor	Same as perceptuo-cognitive	Same as perceptuo-cognitive	observation	observation of oral motor function	Same as general health	WISC or WISC-R (interchangeable) Bender Gestalt If Leiter given-observation	observation
Hearing, Language & Speech	Same as perceptuo-cognitive	Same as perceptuo-cognitive	See next page	See next page	Same as general health	WISC or WISC-R (interchangeable) Note-Leiter only tests language concepts via matching	observation
Personal/ Social Adaptive	Same as perceptuo-cognitive	Same as perceptuo-cognitive	observation	observation	Same as general health	Observation play therapy TAT, CAT, other projectives if indicated	Observation interview with classroom teacher

HEARING, LANGUAGE AND SPEECH TEST (OVER 6)

Hearing	Air and Bone conduction: tests are done according to age and response Downs and Northern Audiometric Assessment (birth - 2 years) Visual Reinforcement Audiometry (2 - 3 years) Tangible Reinforcement Audiometry Hugheson - Westlake Air Conduction Pure Tone Test Hugheson - Westlake Bone Conduction Pure Tone Test
	Speech Reception threshold: (3 months +) Haskins Word Discrimination Test (basic test) (2½ +) CID and Utley Speech Reception Tests (4+) Ross and Lerman Word Intelligibility by Picture Identification
	Impedence Test Battery
	For Children with Sensory-Neurol Losses: Olson-Noffsinger Tone Decay Test, Rosenburg Modified Tone Decay Test, Carhart Tone Decay Test, Jerger and Jerger Suprathreshold Adaptation Test, Short Increment Sensitivity Index, Bekesy Test Battery, Jerger's Articulation Function ("Roll-over") Test
	Central Auditory Test Battery: Berlin Speech in Noise Test; Willeford Central Auditory Test Battery, Katz Shifting Spondaic Word Test
Language - Standard	Peabody Picture Vocabulary Test Oral Commissions Repeat of Digits and Sentences Spencer Memory for Sentences Wepman Auditory Discrimination
Language - Optional	Illinois Test for Psycholinguistic Abilities (ITPS)(for additional assessment,if necessary,of receptive,expressive language, organization abilities, and visual/motor tasks) Daugherty Oral Copy Test (to assess sound sequencing abilities and ability to imitate confusing sound sequences when this area presents problems) Subtests of Detroit Test of Learning Aptitude (to assess further cognitive skills, i.e., discern inferences and absurdities, to assess further auditory and visual memory, and for additional assessment of verbal and auditory abilities)
Speech - Standard	Oral-Peripheral Examination Oral Diadochokinetic Rate Goldman-Fristoe Test of Articulation or Photo Articulation Test

A. Questions Asked in Areas of Primary Concern:

1. Hearing, Language and Speech

a) What is the nature and extent of hearing loss?

(1) What is the degree of hearing loss?
(2) Is the loss conductive, sensorineural, mixed?
(3) Is discrimination impaired even in an optimum listening environment?

b) What is the cause of the loss and type of remediations as related to prevention?

(1) Do the test results and history provide information on the probable cause of the loss?
(2) What is the treatment plan - need for medical intervention, monitoring of the progressive nature of the loss, need for hearing aid(s), need for speech reading or other habilitative/rehabilitative auditory training procedures, need for a deaf educational program, etc?

2. General Health

Any history or physical signs that relate to possible problems in the auditory system?

a) Any positive answers on Audiology Preevaluation Questionnaire (see form following this section)?

b) Any physical signs by professional observation or report which would relate to potential auditory problems (e.g., craniofacial abnormalities, cafe-au-lait spots, defects of digits, etc.)?

B. Procedures/Instruments:

1. Tests Done for All Developmental Ages

a) Speech thresholds - Predictor of degree of hearing loss; indicator for treatment plan. 0-20 dB = normal hearing.

(1) Speech Awareness Thresholds (SAT) (birth - 1½ years) - Speech stimuli presented in a sound field environment with light as a reinforcer as appropriate. Threshold is the lowest intensity eliciting a 50% response.

(2) Speech Reception Thresholds (SRT)

(a) (1½ - 2 years) - Speech is presented through the audiometer at varying intensity levels using selected words as stimuli (usually body parts,

clothing). The child points to the appropriate object in response to the stimulus. An ascending/descending technique is used to establish threshold.

(b) (2 - 4 years) - Picture spondaic words are presented. (Spondaic words have equal stress on both syllables.) The child points to the picutre in response to the stimuli. Techniques for establishing threshold is the same as above.

(c) CID and Utley Speech Reception Tests (4 years +) - Patient repeats spondaic words presented using ascending/descending threshold technique.

b) Air conduction (AC): Assesses degree of hearing loss; indicator of etiology of loss; indicator for treatment plan; does not require understanding of oral language. Normal hearing = 0-20 dB with no conductive component.

(1) Downs and Northern Audiometric Assessment and Visual Reinforcement Audiometry (VRA) (birth - 3 years) - Air conduction tests consist of presentation or narrow-band and/or warbled pure tones at appropriate intensity levels and frequencies in a sound field environment. A light stimulus is used as a reinforcer. At ages 1½ +, earphones may be used with localization. The lowest intensity at which the child responds 50% of the time constitutes threshold. Normal responses can be found in J. Northern and M. Downs Hearing in Children.

(2) (3-4 years) - Play audiometric techniques are used to generate an audiogram of tonal responses across the frequency range. The child is conditioned to hold a block to the ear, putting it down each time a tone is heard. An ascending/descending threshold technique is used with the lowest intensity at which the child responds 50% of the time constituting threshold.

(3) Hughson - Westlake Air Conduction Pure Tone Test (4 years +) - The child is instructed to raise his/her hand or push a button in response to tonal stimuli. Thresholding procedure is the same as for the 3 - 4 year old.

c) Impedance measurements - Assesses middle ear function and suggests types of middle ear pathology; used to rule out severe sensorineural hearing loss; provides information on retrocochlear pathology (Facial and Auditory Nerve Function). Maximum tympanic membrane mobility at $\pm$ 50 mm H_2O and intact reflexes at 70-100 dB - normal results.

This test requires no conditioning on the part of the patient. The patient needs to be immobile for 30 seconds so an airtight seal may be obtained in the ear. During reflex measurements, the patient cannot vocalize.

Generally can be done on patients of any age.

(1) Procedure for tympanogram - An airtight seal is obtained with a probe tip/earplug assembly through which is presented varying degrees of air pressure as well as a probe tone. Eardrum mobility, ossicular dysfunction, significant negative middle ear pressure, eustachian tube dysfunction, aerating tube patency, tympanic membrane perforations, and otitis media can be ascertained.

(2) Procedure for acoustic reflex - With air pressure equal on both sides of the eardrum, an intense tonal, noise, or tactile stimuli is presented and stapedial reflex evaluated. Presence or absence of decay of reflex allows determination of the status of the middle ear, cochlear, and retrocochlear pathways.

2. Other Tests Selected on the Basis of Mental Age and Diagnostic Need

a) Bone Conduction (BC) - Determinant of type of hearing loss (conductive, mixed, sensorineural). Used when air conduction pure tone or speech tests indicate a hearing loss.

(1) Speech Awareness/Reception Threshold (3 months+) - Speech stimuli is presented via a bone conduction oscillator. Response at lowest intensity level constitutes threshold established by following the thresholding procedure indicated in SAT and SRT.

(2) Hughson Westlake Bone Conducted Pure Tone Test

(a) (3 months - 3 years) - Bone conducted warbled pure tones or narrow-band noise are presented through the bone conduction oscillator following the thresholding technique described for air conduction (VRA test).

(b) (3 years +) - Pure tones are presented through the bone conduction oscillator following the thresholding technique described for air conduction.

b) Haskins Word Discrimination Test (2½ years +) - The child is asked to repeat a list of words selected to represent all the sounds in the English language. The sounds contained in each list are also phonetically balanced so that each sound is present with the same frequency as in normal conversation. (Also known as PBK lists.) This test requires that the child has reasonably intelligible speech. (Normal discrimination: 90-100%)

c) Ross and Lerman Word Intelligibility by Picture Identification (used for children with unintelligible speech or for older, hard of hearing children) - The child is asked to point to a specific picture and selects the appropriate one. Six pictures are presented for each stimulus word.

d) Tangible Reinforcement Audiometry (MA 2 - 3 years) - The patient is presented with either tones or speech and is conditioned to push a button in response to sound. When the patient responds appropriately to sound, a tangible reinforcer is given (e.g., candy, cereals, etc.). Test takes about 3-4 hours total and must be done in several test sessions due to lengthy administration. Used when more traditional techniques are unsuccessful.

3. Special Auditory Test Battery (MA 5 years +) - One or more of the following tests are done in conjunction with the tests described in Part I to determine whether the sensorineural hearing loss is due to cochlear or retrocochlear pathology.

a) Tone Decay Tests (5 years +) - The patient is instructed to raise the hand or hold down on a button for as long as the high frequency pure tone is heard.

(1) Jerger and Jerger Suprathreshold Adaptation Test (STAT) - Pure tones of 500, 1000, and 2000 Hz are presented at extremely high intensity levels (which are specific to each frequency and the type of earphones used). The test is negative for retrocochlear pathology if all three tones are heard for the full minute each is presented. The most sensitive tone decay test for retrocochlear pathology.

(2) Olsen-Noffsinger Modification - Tone(s) presented at 80-85 dB SPL. Negative findings for retrocochlear pathology: Tone heard for one minute.

(3) Rosenburg Modification - Tone(s) presented at 5dB above threshold and increased 5dB whenever the patient indicates that the tone is no longer heard. Intensity increases are done for a total of one minute. The test is negative for retrocochlear pathology if the intensity increase is 15dB or less.

(4) Carhart Tone Decay Test - The intensity of the tone is raised in 5 dB steps from threshold level until an intensity is reached at which the patient indicates that the tone can be heard for a full minute. The test is negative for retrocochlear pathology if the intensity does not have to be increased more than 20 dB above threshold.

b) Short Increment Sensitivity Index (SISI) (5 years +) - High frequency pure tones are presented above threshold. At regular intervals the intensity of the tone increases by 1 dB.

(1) High intensity SISI - Tones are presented at 85 dB HL. The test is negative for retrocochlear pathology if 80% of the twenty 1 dB increments are heard.

(2) Traditional SISI - Tones are presented at 15-20 dB above threshold. The test is positive for cochlear pathology if 80% of the twenty 1 dB increments are heard.

c) Bekesy Test Battery (6 years +) - Pure tones are presented with the patient instructed to hold down a button on a hand switch as long as the tone is heard and to release the button as soon as the tone disappears. This results in an automatic intensity tracing in which the continuous tonal stimuli tracing is compared to the tracing for interrupted tonal stimuli. Trackings for the continuous and interrupted tonal stimuli can be obtained for either a fixed frequency or by slowly sweeping the frequency range between 250 and 8000 Hz. If the tracings for the continuous and interrupted tonal stimuli overlap for the duration of the test, the test substantiates normal hearing or conductive hearing loss. If the continuous tracing separates no more than 20 dB relative to the tracing for the interrupted tonal stimuli and the separation occurs after 500 Hz, the test indicates cochlear pathology. If the continuous tonal stimuli tracing separates more than 20 dB from the interrupted tonal stimuli tracing, the test indicates retrocochlear pathology.

d) Jerger's Articulation Function ("Rollover") Test (4 years + with intelligible speech) - Discrimination is measured at varying sensation levels (intensities above threshold). The tester determines the sensation level (SL) at which discrimination ability is maximal. Intensity is increased in 5 dB increments above this optimum intensity level and discrimination is measured at each intensity increase. The test is positive for retrocochlear pathology if discrimination decreases as intensity increases above that which yields optimal understanding. (also known as PBPI test.)

4. Central Auditory Tests: Used when hearing is normal but processing of auditory stimuli is in question. (Developmental ages for each test are indicated.)

a) Berlin's Speech in Noise Test (4 years + with intelligible speech) - Determinant of dominant ear and processing difficulties in noise. Phonetically balanced words are presented at an intensity level of 40 dB above the speech reception threshold. Noise is presented at an intensity level 50 dB above the speech reception threshold. Normal discrimination is 80% or better.

b) Willeford Test Battery (5 years +) - Determinant of ear dominance, processing problems, hemisphere dysfunction, and brain stem synthesis. Each test is presented at specified intensities and is scored according to chronological norms.

(1) Binaural Separation Test - Ear dominance and hemisphere involvement are delineated. Two sentences are presented each to separate ears and at different intensity levels (re: threshold). The child is to repeat the sentence heard in the ear with the least intensity level.

(2) Filtered CNC Words - Delineates ear dominance and hemisphere involvement. Single syllable words with a consonant-vowel nucleus-consonant (CNC) pattern are filtered so that only frequencies below 500 Hz are heard. The child repeats the word heard.

(3) Binaural Fusion Test - A test of brain stem synthesis and may identify brain stem lesion. Two syllable words are presented with the low frequency components of the word being presented to one ear and the high frequency components presented to the opposite ear.

(4) Alternating Speech Perception Test - Test for brain stem processing of contextual information. Parts of the stimulus sentences are presented in alternating 300 msec segments, first to one ear then to the other. The child is to repeat the entire sentence.

c) Katz' Shifting Spondaic Word Test (SSW) (6 years +) - Specifies location of hemisphere lesion. A spondaic word (equal stress on both syllables) is presented to one ear. While the second syllable of the word is being spoken, the first syllable of the next spondaic word is being presented to the opposite ear. This procedure alternates (with first one ear then the other receiving an undistorted first syllable). The child repeats all words heard. Normal hemisphere function is indicated by correctly repeating 90% of the stimulus words.

C. Assessment Work Forms:

1. Preevaluation questionnaire (Core History provides some of this information).

2. Recording sheet.

AUDIOLOGY PRE-EVALUATION QUESTIONNAIRE

Date:_____

NAME:_____

INFORMANT:_____

REFERRED BY:_____

DESCRIPTION OF PROBLEM:_____

_____

BIRTH & DEVELOPMENTAL HISTORIES

	NO	YES
1. Problems with the mother's pregnancy (e.g. rubella?	( )	( )
Specify_____		
_____		
2. Problems during delivery?	( )	( )
Specify_____		
3. Problems during the newborn period?	( )	( )

	No	Yes
a) Oxygen required?	( )	( )
b) Jaundiced at birth or afterwards?	( )	( )
Treatment: ( )phototherapy ( )transfusion		
c) Birth weight 4 lbs. or less?	( )	( )
d) Other (specify)_____		

4. Development delayed?	( )	( )
a) Delayed in walking?	( )	( )
b) Delayed speech: first words other than "mama" or "dada" later than 16 mos?	( )	( )

****

HEALTH HISTORY

1. Had any childhood diseases?		( )	( )
		Immunized?	
	Age of Occurence	No	Yes
Mumps	_____yrs	( )	( )
Measles (2 weeks)	_____yrs	( )	( )
Measles (3 days, rubella)	_____yrs	( )	( )
Chicken pox	_____yrs	( )	( )

HEALTH HISTORY Continued

	NO	YES
2. Serious illnesses?	( )	( )

(Check appropriate illness)

( )scarlet fever
( )meningitis
( )tuberculosis
( )other:_____
( )seizures
( )undiagnosed viruses
( )encephalitis

OTHER HISTORY RELATED TO SENSORINEURAL HEARING LOSS

1. Fever of 104° for 8 hours or longer?	( )	( )
2. Temperature _____° Illness:_____ Duration _____hrs Age_____yrs Medical help? ( )Yes ( )No		
3. Head injury (causing loss of consciousness)?	( )	( )
4. Dizziness (vertigo)?	( )	( )
5. Tinnitus? (Specify) ( )ringing ( )roaring Right, Left, Bilaterally	( )	( )
6. Exposure to excessive loud noise (e.g. cap pistols, firing range, guns, industrial noise, firecrackers close to patient, power tools, etc.)?	( )	( )
7. Familial history?	( )	( )

****

HISTORY RELATED TO CONDUCTIVE LOSS

1. Excessive wax?	( )	( )
2. Q-tips used?	( )	( )
3. History of ear infections?	( )	( )

No. of occurrences

( )before 1st birthday _____
( )prior to 5 years of age _____
( )6-12 years of age _____
( )adolescence _____
( )adulthood _____

Last occurrence_____
Name of MD who treated last occurrence_____
Type of treatment_____

4. Drainage from ears?	( )	( )

Last occurrence_____

HISTORY RELATED TO CONDUCTIVE LOSS Continued

	NO	YES
5. Frequent colds (more than 3 a year)?	( )	( )
6. Snore?	( )	( )
7. Mouth breathe?	( )	( )
8. Allergies?	( )	( )

Allergic to _____
Medications and dosage_____ Injections: ( )Yes ( )No
Name of allergist:_____

****

CURRENT STATUS

1. School problems?	( )	( )
2. Cold/ear infection/allergy today?	( )	( )
3. On medication today?	( )	( )

HEARING, LANGUAGE AND SPEECH PROGRAM
MONTGOMERY COUNTY HEALTH DEPARTMENT

15701 TWINBROOK PARKWAY, ROCKVILLE, MD. 20853
(TEL: 279-1761)

AUDIOLOGIST: _____ DATE: _____

NAME: _____

ADDRESS: _____

AGE: _____ SEX: _____ BIRTHDATE: _____

SCHOOL: _____

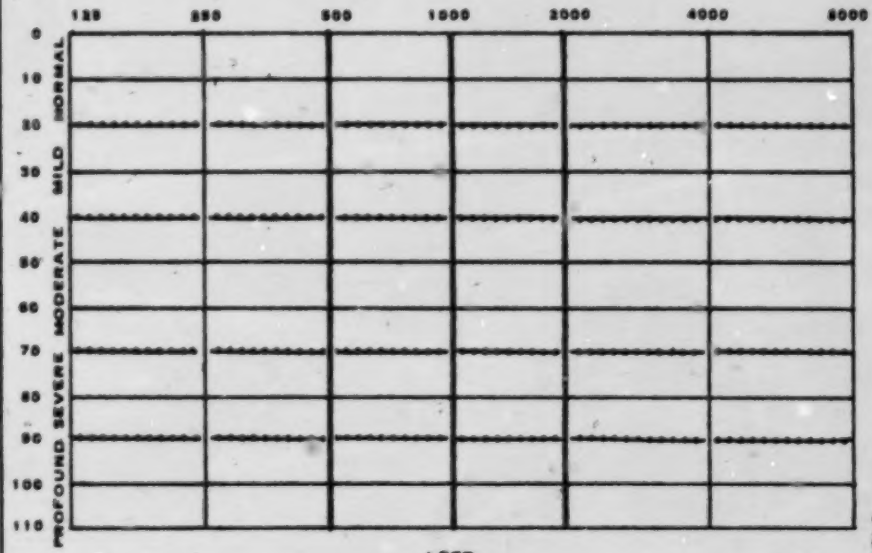
	THREE FREQUENCY AVERAGE	TWO FREQUENCY AVERAGE
RIGHT	_____ dB	_____ dB
LEFT	_____ dB	_____ dB
BINAURAL	_____ dB	_____ dB

	SPEECH RECEPTION THRESHOLD	DISCRIM. (PHONETIC BALANCE)	LEVEL	REF.
R	_____ dB	_____ %	_____ dB	_____
L	_____ dB	_____ %	_____ dB	_____

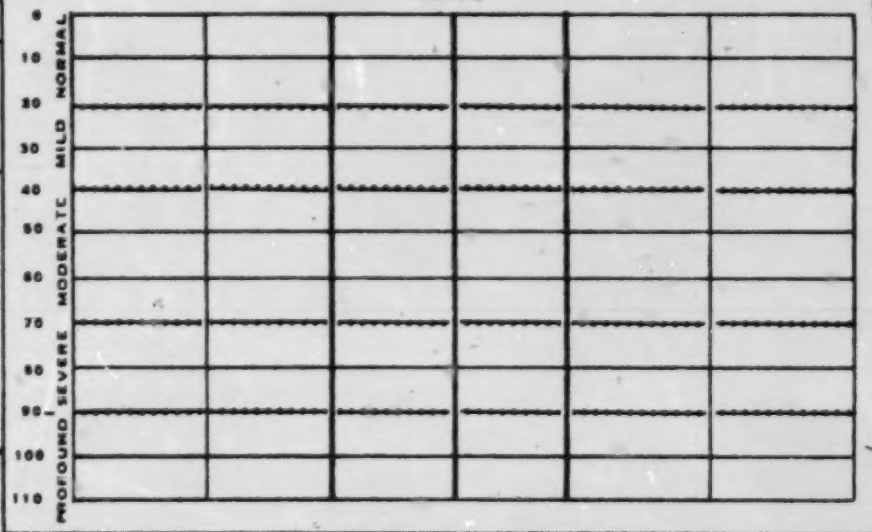
SRT (UNAIDED)	SRT (AIDED)	DISCRIM. (AIDED)
_____ dB	_____ dB	_____ %

PURE TONE AUDIOGRAM

RIGHT HERTZ

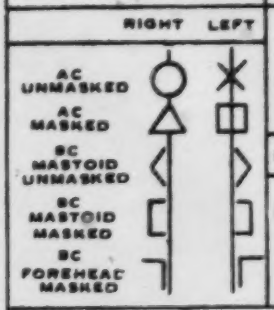


LEFT HERTZ



DECIBELS ANSI SCALE, 1969

AUDIOGRAM KEY



BOTH

NO RESPONSE SYMBOLS

REMARKS:

CF:

HEARING AID INFORMATION:

MAKE: _____ MODEL: _____

EAR: _____ ADJUSTMENTS: _____

BATTERY: _____ RECEIVER: _____

IMPRESSION:

RECOMMENDATIONS:

H&S 1 REV 1/76

A. General Approach to Investigating All Developmental Areas

1. General Health

Observation for
(1) Scars, cuts, bruises, obvious dysmorphic features
(2) Signs of any cold or illness
(3) Eyes - clarity and alertness
(4) Overall physical stature - height and weight to be judged within normal limits
(5) Any obvious physical handicaps

2. Perceptuo-Cognitive

a) All aspects of visual learning
(1) Perception
(2) Discrimination
(3) Figure ground
(4) Closure
(5) Spatial awareness
(6) Motor integration
(7) Memory
(8) Object permanence
(9) Directionality
(10) Part to whole

b) Problem solving
c) Basic concepts
d) Comprehension of question forms
e) General knowledge of environment
f) Self-concept
g) Direction following
h) Memory
i) Reasoning (analogies and opposites)

3. Gross Motor

a) Locomotion
b) Ambulation
c) Balance
d) Strength
e) Body awareness
f) Dominance
g) Motor integration
h) Reciprocal movements
i) Overflow movement
j) Body control

4. Fine Motor

   a) Eye hand coordination
   b) Grasp and release
   c) Pencil grasp/handedness
   d) Visual motor integration
   e) Small muscle coordination
   f) Prewriting skills
      (1) Imitation
      (2) Copying
      (3) Tracing
      (4) Drawing
      (5) Directionality

5. Hearing, Language, and Speech

   a) Sound localization
   b) Sound imitation
   c) Word imitation
   d) Vocabulary
   e) Length of utterances
   f) Intelligibility of speech
   g) Understanding of basic concepts
   h) Direction following
   i) Some components of auditory learning
      (1) Memory
      (2) Perception
      (3) Discrimination
   j) Ability to tell stories and express self
   k) Understanding of basic concepts dealing with
      (1) Time
      (2) Space
      (3) Direction
      (4) Quantity

6. Personal/Social Adaptive

   a) Reaction to strangers
   b) Separation
   c) Toileting
   d) Dressing
   e) Eating
   f) Personal hygiene
   g) Peer/adult relations
   h) Quantity and quality of play
   i) Attention span
   j) Task completion
   k) Learning style
   l) Response to limits and demands and a stimulating nursery class environment
   m) Self-concept
   n) Response to stress and frustration

Since the nature of the educational diagnostician's role in the assessment procedure of a child under 6 is developmental in nature, all areas would be assessed using all items. If, however, the child demonstrates obvious physical limitations, the assessment is adjusted accordingly. Because the nature of the team is interdisciplinary, the amount of time spent assessing each developmental area varies. The child's comprehensive developmental profile of strengths, weaknesses, and significant delays are then interpreted to the rest of the team to complete the overall evaluation. At that time the educational diagnostician develops a general Educational Management Plan for the child in light of the team's findings.

B. Procedures/Instruments

1. The Memphis Comprehensive Developmental Scale - This tool is designed to assist the teacher in finding a child's present level of functioning in the five primary developmental areas. The scale is applicable to youngsters who are developmentally between birth and five years of age. The scale is divided into five subscales for each developmental area with skills which are then easily translated into individual program plans for the child.

   Testing and programming materials may be obtained through Fearon Publishers, Inc., 6 David Drive, Belmont, California 94002.

2. The Learning Accomplishment Profile (LAP)-The Infant Learning Accomplishment Profile (ILAP) - These are designed to provide the teacher of the young child (infant - 6 years) with special needs, a simple criterion-referenced record of the child's existing skills. They are detailed, developmentally based instruments which are easily translated into appropriate learning objectives for each individual child which allows the teacher to measure progress through changes in rate of development and provide specific information relevant to pupil learning.

   Testing materials may be obtained through Kaplan Press, 600 Jonestown Road, Winston Salem, N.C. 27104.

3. Boehm Test of Basic Concepts - This is designed to measure a child's mastery of concepts considered necessary for achievement in the first years of school. The test is appropriate for use with children from Kindergarten-Grade 2. The results may be used both to identify the child with deficiencies in this area and to identify individual concepts on which the child needs instruction.

   Testing materials may be obtained through The Psychological Corporation New York, New York.

4. Slingerland Screening Test - This is an indepth tool for Grades 1-4 to screen from among a group of children those with potential or already existing difficulties who are in need of immediate attention or preventive remediation. Its primary objective is to identify children whose specific language difficulties may continue beyond periods of developmental or maturational lags and may become persisting specific disabilities.

4. (Continued)

Testing materials may be obtained through Educators Publishing Service, Inc., Cambridge, Mass. 02138.

5. Metropolitan Readiness Tests - This battery of tests measures the wide range of readiness skills for kindergarten and first grade pupils at different stages of skill development. It is a norm-referenced test which presents a percentile rank, stanine, performance rating, and scaled score for either an individual or group of children.

Testing materials may be obtained through Harcourt Brace Jovanovich, Inc., New York, New York.

6. Silvaroli Classroom Reading Inventory - This is a diagnostic tool for Grades 2-10 which provides information concerning the child's independent, instructional, and frustration reading levels. In addition, it assesses the child's specific word recognition and comprehension abilities.

Testing materials may be obtained through William C. Brown Company Publishers, Dubuque, Iowa.

7. Stanford Achievement Tests - This standardized tool measures children's academic achievement from Kindergarten through grade 9. It is an extensive battery of tests measuring all areas of learning and requires at least two full days to administer. It can be administered individually or in a group yielding a percentile rank, stanine, grade equivalent score, and scaled score for all areas.

Testing materials may be obtained through Harcourt Brace Jovanovich, Inc., New York, New York.

8. Letter, Name, and Sound Survey/Sound Blending Survey - This survey is designed to enable teachers to determine which letter, names, and corresponding sounds a child has learned and how well he approaches the process of blending the sounds into recognized syllables. It further aids the teacher in developing a beginning program of decoding processes for the child who needs these particular prereading skills. It also provides a graphic checklist of progress to the child, teacher, and parent.

Testing materials may be obtained through Montgomery County Public Schools, Diagnostic and Professional Support Team, 850 Hungerford Drive, Rockville, Maryland.

C. Assessment Work Forms:

Scoring sheets and/or workbooks of above listed tests.

NURSE COORDINATOR

A. Questions Asked in Areas of Primary Concern:

1. General Health - Information is gathered to determine the past and current health status of the child and family:

   Questions asked deal with prenatal, birth, and neonatal history; significant past medical history (accidental ingestions, accidents, serious or chronic conditions); developmental milestones; significant habits; and current social and health status. Also, what previous evaluations has child had? How recent? If current, DESC would not repeat these. Instead a partial evaluation would be scheduled.

2. Personal Social Adaptive - How do the child's peer and familial interactions relate to the presenting problem(s)?

   Questions are asked concerning peer relationships, play styles, activity level, physical restrictions, if any, and parental and school management.

B. Procedures/Instruments:

1. The basic Core History is taken via telephone interview or office or home visit. This history provides background information and a profile of the child and family. It also provides information about parental concerns, when problem was first noted, what prompted call to DESC at this time, child-family interaction, and parental goals for child. It serves as a data base and includes reason for referral and narrative history of problem.

2. The Denver Developmental Screening Test (DDST) is usually administered when gathering intake information on a home visit. This screening tool may pinpoint areas of delay for later reference for the DESC team.

C. Assessment Work Forms:

Core History Form and Criteria.

DEVELOPMENTAL EVALUATION SERVICES FOR CHILDREN

CORE HISTORY

Date: _____

Name: _____ B.D. _____ Parents _____

Address: _____

Phone: _____ Referred by: _____

PMD: _____ Phone: _____

REASON FOR REFERRAL: Informant: _____

I. HISTORY OF PROBLEM:

AGENCIES:

MCHD Health Center _____ CHN/SMA _____

Dept. Social Services _____ Social Worker _____

School _____ Teacher _____

II. PRENATAL, BIRTH, NEONATAL HISTORY:

A. Pregnancy: Mother's age at time of pregnancy___; no. of pregnancies ___; no. of live-born children___; birth order of patient___; planned___; duration of pregnancy_____; special problems (smoking, alcohol, medication, x-ray exposure, bleeding, amniocentesis, emotional problems, diabetes, hypertension); weight gain___.

Significant positive findings:

B. Delivery: Labor <4-16> hours____; premature rupture of membranes_____; Caesarian Section (give indication below)___; forceps___; anesthesia_____; multiple birth___; birth weight_____; condition at birth_____; Apgar_____; name of hospital_____.

Significant positive findings:

C. Neonatal: Respiratory problems___; infection___; jaundice (give duration and treatment below)___; feeding problem___; frequent formula changes___; discharged with mother_____.

Significant positive findings:

Note mother's early contact with baby and personality of baby:

III. PAST MEDICAL HISTORY:

A. Accidents___; accidental ingestion or lead poisoning___; serious or chronic conditions___; allergies___; temperature 104°____.

Significant positive findings:

B. Hospitalizations:

Hospital	Age	Duration	Reason

C. Immunizations: DPT: Measles:
OPV: Rubella:
Tbn skin test: Mumps:

IV. DEVELOPMENT:

A. General

Sat alone___; walked___; first words (other than mama, dada)___; three-word phrases___; toilet-trained___; rode 3-wheeler___.

Comments:

B. Vision:

Any concern__; blinks or rubs eyes___; holds small objects closely ____; crossed eye___; wandering eye; especially before bed___.

Comments:

C. Hearing:

Any concern___.

Comments:

D. Speech and Language:

Any concern___; understood by parents___; by others___; follows instructions___; foreign language spoken in home_____.

Comments:

E. Motor Adaptive:

Any trouble sucking, swallowing, chewing___; abnormal movements or weakness___; orthopedic problems___; clumsiness___.

Comments:

F. Self-help skills:

Note present level.

G. Behavior

Attention span_____; activity level_____; temper tantrums_____; rocking___; head banging___; self mutilation___; aggressiveness___; fearfulness___; ability to separate___; peer relationships_____. Does he enjoy stories, puzzles, blocks, music, cars, dolls?

Comments:

H. Sleep Pattern:

V. PREVIOUS SCHOOLS ATTENDED:

School	when attended	why left

VI. PREVIOUS EVALUATIONS:

Examiner	Specialty	Date	Where done	Results

VII. FAMILY/SOCIAL HISTORY:

A. Family:

Consanguinity___; diabetes___; stroke, hypertension or heart attack under 50___; physical deformities___; cerebral palsy___; mental retardation___; speech/language problem___; learning problem___; reading problem___.

Comments:

B. Social:

Household members:

Name	Age	Relationship	Education Level	Occupation	Health Info.

PEDIATRICIAN

A. Questions Asked in Areas of Primary Concern:

1. General Health - The Core History is studied and amplified to include details of presenting problem, allergies, unusual childhood diseases, operations, hospitalizations, accidents including ingestions, pica, and immunization history. The following information is asked to determine the general health history and health practices of the family:

   a) Medication history - Has the patient been given any medications for longer than two weeks? For what were these medications given? What were the family attitudes toward the medicines? What was the effect of the medication?

   b) Nutritional history - Questions are asked concerning appetite, the nutritional value of the diet, self-help skills related to eating, any unusual eating habits such as prolonged use of the bottle, eating only soft foods or special diets, and general behavior relating to eating such as does the family eat together and how does the patient behave during that time?

   c) Family history - Explore in detail familial developmental problems and to identify any familial diseases which might require testing of child at present (i.e., early heart disease).

   d) Present health - How many days were missed from school during the past year? How many calls to the pediatrician were made in the last year? Does the child have any complaints? If height, weight, or head circumference are small, the family is asked whether the child has always been the same size related to other children his age or had growth spurts or arrests?

      1) Head, eyes, ears, nose, and throat - Does the child snore, mouth breathe, have nose bleeds, brush his teeth, visit the dentist, or sneeze and have itching eyes? (See Core History of vision and speech symptoms also.) Details of any specific ear, nose, throat, or eye examinations are included in this section.

      2) Chest - Is the child troubled by a cough or wheezing? Has the child had pneumonia or asthma?

      3) Heart - Does the child fatigue easily or has he ever been said to have a heart murmur or heart trouble? Details of any cardiac evaluations are obtained.

4) GI - does the child complain of abdominal pain, have trouble with vomiting, constipation, diarrhea, or soiling? What treatments are used?

5) GU-GYN - has the child ever had urinary tract infection? Toilet training history and present status of daytime and nighttime wetting are taken. In the case of girls, a discharge from vagina is inquired about.

6) CNS - has the child ever lost consciousness, had a seizure or convulsion, headache, weakness in an arm or a leg, had a limp,or head-banging episodes?

7) Orthopedic - has the child had any past orthopedic consultations, worn braces or special shoes, or had a postural problem?

8) Skin - has the child had any unusual skin lesions, birth marks, or chronic rashes?

2. Fine and Gross Motor - Core History supplies basic information which is amplified by specific questions including: What is a typical day like ? How does he react on the playground? Can he climb? Does he use the slide? Can he pump himself on the swing? How does he perform on the stairs? Does he zip, button, unbutton, snap, and unsnap? How does he feed himself?

B. Procedures/Instruments:

A general pediatric exam is performed as indicated in the pediatric guide. The neurologic exam is done as best possible using the pediatric guide which contains detailed mention of the tests done on the child. Since the pediatric and neurologic exams are not standardized tests, different parts are omitted if the child is impaired.

C. Assessment Work Forms:

Core History and Pediatric Guide are used.

DEVELOPMENTAL EVALUATION SERVICES FOR CHILDREN
PEDIATRIC EVALUATION
A Guide to Supplement Core History

Summary of Present Illness:

Significant Past Medical History:

Prenatal, Birth and Postnatal -

Development -

Immunizations -

Hospitalizations -

Operations -

Accidents or Injuries -

Allergies -

Medications -

Nutritional History:

Significant Family Medical History:

Review of Systems:

General Health -

HEENT -

Pulmonary -

Cardiac -

GI -

GU-GYN -

Musculo-Skeletal -

CNS -

Physical Examination:

Hgt. (percentile) Wt. (percentile) HC (percentile) BP

Vision Screening Results:

General (appearance):

Skin:

HEENT:

Head -
Eyes -
Nose -
Ears -
Mouth -
Teeth -
Oropharynx -

Neck:

Lymph Nodes:

Chest:

1) Lungs -

2) Heart -

3) Pulses -

Abdomen:

Genitalia:

Ano-Rectal:

Extremities - joints and back:

Dysmorphic features:

Neurological:

1. Mental status:
   Level of activity/emotional state -

   Orientation in time and place -

   Ability to relate and separate -

2. Language/Speech:
   Speech (amount + quality) -

   Language -

3. R-L Dominance - Hand:
   Eye -
   Foot -

   R-L Orientation:
   One Side -
   Across Midline -

4. Cranial Nerves:

5. Station: Gait: Romberg:

6. Motor:
   a. Muscle Mass - Power - Tone -

   b. Coordination -
      Gross Motor: ball tasks -
      jumping, hop, skip, balance -
      heel walking -
      tandem walk forward -
      heel to knee -
      toe walking -
      tandem walk backward -

      Fine Motor: eye movements -
      pincer grasp -
      pencil grasp -
      block building -
      finger to nose -
      rapid alternating hand movements -
      oral motor coordination -
      finger to finger -
      dressing/undressing -
      any paper pencil tasks -

      Associated Movements:

      Involuntary Movements:

      Stereotyped Movements:

   c.

Reflexes	biceps	triceps	Brach-rad	knee	ankle	clonus	plantar	abd.	other
R									
L									

7. Infant Reflexes:

8. Sensation:
   a. Touch, pain, temperature -

   b. Position -

   c. Stereognosis/Graphesthesia -

   d. 2 point discrimination -

   e. Finger praxis -

   f. Vibration -

PSYCHIATRIC SOCIAL WORKER

A. Questions Asked in Areas of Primary Concern

1. Personal/Social Adaptive - Family-Social History - The focus is upon assessing and evaluating the impact of the presenting concerns upon the overall family functioning and becoming knowledgeable of the family system whereby recommendations will be sensitive to the total family needs and culture.

   a) Concerns: What are the family's (parents, siblings, etc.) concerns regarding the child? What is the degree of agreement or disagreement regarding the concerns?

   b) Birth and Developmental History: What was the social/emotional/financial impact of the pregnancy and birth of child? How old was your child when you started to view her/his development as being noticeably different from his siblings, peers, etc.?

   c) Family History: How did you meet? Is this the first marriage for both of you? If not, how were the former marriages terminated? Who are the children who have been born to this union? Other unions? What are your plans for the continuation of the marriage?

      (1) Father and Mother - When, where were you born? What is your birth order? Are both parents still living? What is their health status and your responsibility towards them if ill? What was the cause of death and impact upon family?

      How would you describe yourself now and as a student? Did you or any member(s) of your extended family have school related problems? What is your educational background and current employment?

      (Other questions as appropriate and generated by interview.)

      (2) Children - Tell me about the children in the family. Do you have any concerns about any one of their growth and development?

      (3) Family Relations - What is the quality and/or quantity of family interaction, ie., parent-child, child-siblings?

      (4) Peer Relationship - Does your child play with peers? Older? Younger? What is the quality of his relationships with peers? Do you receive frequent complaints from neighbors about your child?

   d) Child Management: What are your individual views on child management? How are children in the family disciplined? Is this child handled any differently than the other children? Are you experiencing difficulty in managing any of the children?

e) Daily Schedule: What is your schedule? Is time alone with child planned into schedule? Is time planned for skill building with this child? What are needs of other children? Does parent have opportunity to meet own needs?

f) Parent Response: What is it that you thought would be asked, but was not?

g) Expectations: What do you expect to happen at the completion of the evaluation? What do you understand as the role of DESC?

2. General Health, perceptuo-cognitive, gross and fine motor and hearing, and language and speech development are assessed as integral parts of the family social history interview as well as in collaboration with other team members.

B. Procedures/Instruments

Social History outlined above developed by social worker which addresses itself to the total family as well as needs of the program.

C. Assessment Work Forms

The assessment of the family is via personal interview preferably with both parents. The child is also seen briefly and, when appropriate, requested to participate in the interview. The form of this assessment is summarized in A (above).

PSYCHOLOGIST

A. Questions Asked in All Areas

1. General Health Questions - Does the child see correctly? Wear glasses, need glasses? Is the child well today? Is child on medication that might affect responsiveness? Does child have physical handicaps, neurological involvement? Is the child sleepy? Is the child hungry?

2. Perceptuo-Cognitive - Aside from qualitative information gained through observation, the questions asked are from standardized tests.

3. Gross Motor - Does child walk well? Does the child fall, trip, etc.? How does the child maneuver around the office? Is child physically capable of manipulating presented materials? Has the child's cognitive development been delayed due to lack of opportunity associated with physical movement limitations?

4. Fine Motor - How well does child manipulate materials? Is it motorically difficult for the child to perform what he intellectually knows how to do? Are there tremors? Are there difficulties in coordinating two part body movements? Does the child manipulate things in unusual ways? Does child perform better with one hand or another? Is dominance established? Question is also in part answered by the ability to perform specific age level tasks.

5. Hearing, Language and Speech - Can this child hear? (Usually this has been evaluated prior to my evaluation). Can this child be understood? Is it necessary to repeat questions? Does his performance improve if questions are rewarded? Can this child express his knowledge in a way that others can understand? What is the quality of his responses? In addition the performance on standardized tests questions relate to this area.

6. Social Emotional Development - How does the child relate to parents, peers, the examiner? How does child respond to success, failure, stress, structure? Does child initiate interactions, respond to overtures from others? What is child's predominant mood? Is the child emotionally labile? What comforts child? What upsets the child? How much intervention is needed to comfort child if the child is upset? From whom does the child seek support and comfort? How does the child separate? Is the child able to amuse himself? What toys does the child choose to play with? Is play creative? Does child involve others in play? Is the play organized? Are there themes to his play? What are the themes? Is child fearful, fretful, happy, sad, etc.? List is endless.

B. Procedures/Instruments

1. Cattell was chosen because it is a widely used and generally accepted measure of infant intelligence for ages from 2 months to 4 years. It has the added advantage of being a downward extension of the Binet which is the most widely accepted individual I.Q. test for children in the 2 to 4 year old range.

2. Stanford-Binet L-M is used for children between the 2 to 4 year old range or for those older who are suspected of having a basal below the 4 year old range. This test is generally recognized by psychologists as being well validated, reliable, and standardized and is one of the most widely used individual I.Q. tests for children in the 2 to 4 year range. It is the test against which most other measures of intelligence are validated.

3. The Wechsler Preschool and Primary Scale of Intelligence (WPPSI) is used for children between the 3.10 to 6.7 year range. It is standardized, validated, and reliable measure of intelligence used widely by psychologists. Where the WPPSI and Binet overlap, the choice is one of professional judgment. If a child is at the younger age range for administering the WPPSI and is suspected of being developmentally delayed, the Binet is often chosen because it allows for a wider sampling of responses by virtue of being able to give questions at a younger age. The WPPSI is often chosen when a child in the 4 to 6½ year old range is not suspected of overall intellectual delays, but there is a question of unevenness in development. The separation of the test into verbal and performance measures as well as subtests can often facilitate pin pointing specific problem areas.

4. The Wechsler Intelligence Scale for Children (WISC) and the Wechsler Intelligence Scale for Children-Revised (WISC-R) are the two most widely used and accepted tests of individual intelligence used by psychologists. Either test is considered to be appropriate in the 6 to 15 year old range.

5. The Leiter is a nonverbal intelligence test that is used in very specific cases primarily for children with hearing impairments or those without an English language or American cultural background. It is sometimes used in addition to one of the verbally based intelligence tests where there is a known or suspected language disorder and one wants to compare performance on verbal and nonverbal tests. It is standardized for use from ages 2 to adult.

6. The Bender Gestalt is a test of visual-motor perception. It consists of a series of 9 figures which the child is asked to copy. Using the Kopitz scoring method for children ages 5 to 10, one is able to rate a child's perceptual motor development. This

in combination with other data may help to diagnose learning disabilities and behavioral disorders associated with perceptual immaturity.

7. The Children's Apperception Test (C.A.T.) is a projective test for young children developed by Leopold Bellach,M.D. In his own words it is described as "a method of investigating personality by studying the dynamic meaningfulness of individual differences in perception of standard stimuli." (Leopold Bellach - Children's Apperception Test, C.P.S. Larchmont, N.Y. 1949). It is used with children who are sufficiently verbal to label and tell stories about pictures. It is used when we wish to investigate emotional factors, particularly a child's relationship with significant others, which may be interfering with his development.

8. Thematic Apperception Test (T.A.T.) is similar to the C.A.T. in its purpose. It consists of pictures of humans in a variety of situations as opposed to animals. It is used with the older, more sophisticated child or with an adult. Its administration and interpretation must be done by mental health personnel specifically trained in its administration.

C. Assessment Work Forms: None

SPEECH PATHOLOGIST

A. Quebtions Asked in Areas of Primary Concern

1. What is the child's total speech and language status?

   a) Does the child understand language at a level commensurate with his age?

   b) Does the child use language at a level commensurate with his age?

   c) What is the status of his articulation, his voice quality, his pitch level, and the rhythm of his speech?

   d) Does he exhibit any difficulties with word retrieval, auditory memory, organization of verbal expression?

2. Perceptuo-cognitive - Can this child understand what is presented?

   a) Does the child's intellectual capacity seem to be adequate for understanding of the specific language items presented to him?

   b) Does he have basic concepts that are appropriate for his age and that reflect basic understanding of words?

B. Procedures/Instruments:

1. The Informal Assessment - Includes observation of the child's general performance and behavior, his attention, concentration and interest, his motor abilities, and his rapport with the examiner. Provides a way to learn more about the child's understanding of basic concepts, awareness of self, and the meaning and use of objects, toys, and books. Also aids in understanding how the child's experiences may contribute to his performance and his behavior.

2. Cognitive Skills Assessment Battery for Pre-Kindergarten and Kindergarten by Boehm and Slater - Designed to provide a profile of several competencies mastered by prekindergarten and kindergarten children (basic information, body parts, large muscle coordination, visual-motor coordination and copying, color and shape identification, symbol and letter discrimination, visual-auditory discrimination, auditory discrimination and memory (words and sentences), visual memory, etc. Might not be administered routinely since it covers areas evaluated more extensively by the educational diagnosticians and/or psychologists.

3. Peabody Picture Vocabulary Test - Measures knowledge of single words. Designed to "provide an estimate of a subject's verbal intelligence through measuring his hearing vocabulary." Can be used for persons who are developmentally between ages 2 and 18.

4. The Carrow Test for Auditory Comprehension of Language - Measures "auditory comprehension of language structure and determines the child's areas of linguistic difficulty for purposes of educational planning and intervention." Can be administered in English or Spanish. Designed for use with children who are developmentally from 3 to 7 years.

5. Gesell Action-Agent Test - Used as a supplement to other language comprehension measures. Used with children who are developmentally between the 3 and 5 year levels. Includes 20 short questions that require a verbal response to indicate the agent that performs a particular action (What sleeps? What floats? etc.).

6. Houston Test of Language Development - Designed to "measure the development of language in children up to three years of age." Includes items at each age level from 6 months to 3 years that represented the various aspects of language, both from the broad classifications of reception, conceptualization, and expressions and the more specific categories of melody, rhythm, accent, gesture, articulation, vocabulary, grammatical usage, and dynamic content. Scored on basis of reponses observed by the examiner (and not merely reported by the parent).

7. Bankson Language Screening Test - Developed as a screening test for use with children who are developmentally between 4 and 8 years. Designed to obtain information about expressive language. Also obtains information about child's knowledge of grammatical rules and visual and auditory perception (memory, sequencing, and discrimination).

8. Oral Commission's Sub-test of the Detroit Test of Learning Aptitudes - Assesses a child's ability to follow one - through four-step directions; most useful for children who are developmentally at least at the 3-year level and can be used for children who are developmentally to age 8. Used as an indicator of auditory memory for verbally presented information and as an indicator of attention and concentration.

9. Repetition of digits and sentences - Used in determining ability to recall verbally presented information. Can be administered to children who are developmentally from approximately 2½ through 6 (and older).

10. Goldman-Fristoe Test of Articulation and/or Photo Articulation Test - Assesses the child's articulation in words and sentences and his ability to improve articulation production following demonstration and instruction. Used in conjunction with the oral examination (including diadochokinetic rate) that assesses structure and function of the oral mechanism.

11. Illinois Test of Psycholinguistic Abilities (ITPA) - Designed to be administered in its entirety to children who are developmentally between 2 years-4 months and 10 years-3 months. Should not administer individual subtests selectively since test interpretation requires administration of all subtests. Designed to assess language from the psycholinguistic model that includes reception, organization, and expression of language via auditory, visual, or manual modalities.

12. Test of Language Development (TOLD) - Designed to assess aspects of a child's abilities in semantics, syntax, and phonology. Assesses understanding of single words and syntactic forms and grammatic markers; ability to imitate sentences (word order and grammatic markers), understand and use common grammatic forms, recognize differences in significant speech sounds, produce sounds in speech, and give oral definitions. Designed for use with children between the ages of 4 and 8.

13. Daugherty Oral Copy Test - Consists of 25 words of confusing sound sequences. Assesses ability to sequence sounds in words.

14. Wepman Auditory Discrimination Test - Consists of 40 word pairs that are equated for length. Designed to determine the child's ability to recognize the fine differences that exist between the phonemes used in English speech.

15. Spencer Memory for Sentences Test - Made up of sentences of increasing length and syntactic complexity. Assesses the child's ability to repeat information presented verbally by the examiner.

C. Assessment Work Forms: None

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C. Assessment Work Forms: None

SECTION III: ADMINISTRATIVE RESPONSIBILITIES IN ASSESSMENT

Preface

Section III delineates the administrative roles and functions essential to DESC assessment. In this section, the roles of case manager, secretary, and project administrators are detailed. The administrative aspects of the coordinator's role are included.

RESPONSIBILITIES OF PROJECT ADMINISTRATOR - EDUCATION

1. Administers and supervises the education components
2. Serves as liaison between project and education personnel
3. Sees that project reports are completed
4. Evaluates education personnel in the project
5. Serves as liaison with health department administrator

RESPONSIBILITIES OF PROJECT ADMINISTRATOR - HEALTH

1. Coordinates and/or supervises health professionals
2. Serves as liaison between the project and other health professionals
3. Acts as consultant to coordinator about on-site administrative problems
4. Evaluates medical personnel in the project
5. Serves as liaison with public school administrator

ADMINISTRATIVE RESPONSIBILITIES OF PROJECT SERVICE COORDINATOR-NURSE COORDINATOR

1. Coordinates all components of the project under the direction of the project administrators for health and education
2. Oversees statistical data collection and is responsible for analysis of data in conjunction with the evaluation specialists
3. Attends all administrative meetings and records minutes
4. Participates in Advisory Council meetings and records minutes of meetings
5. Directs clerical personnel in program related duties

RESPONSIBILITIES OF SECRETARY

1. Takes all ipcoming phone calls relative to DESC and provides information about the service

2. Fills in identifying information and reason for referral on DESC Evaluation Record Summary Form (Intake Form) and refers to nurse coordinator

3. Types schedule of evaluation as outlined by DESC coordinator and routes to:

   a) Each listed evaluator
   b) Area nurse, if indicated
   c) Appropriate health or education personnel
   d) Private physician
   e) Parents
   f) Transportation providers

4. Reserves staff and parent conference time on conference room calendar and also posts regular weekly intake dates on calendar

5. Prepares a DESC record folder with appropriate dividers and forms

6. Checks Montgomery County Health Department Central Index and records DESC service and date on card if previously indexed. If not, types an index card and files in central file

7. Monitors in and out flow of DESC records

8. Delivers record to clinic area prior to date of pediatric evaluation with Children's Specialty Consultation Service (CSCS) record if known to CSCS service

9. Coordinates with CSCS secretarial staff in report filing and record maintenance

10. Types evaluation reports and case conference summaries, has them signed and dated, and then files and sends to specified sources

11. Notes on Evaluation Record Summary Form the dates reports are sent out

12. Notifies case manager when six-week followup contact is due

13. Assists with data collection and statistical reporting

14. Attends in-service meetings

15. Sends Progress Report Forms to program providers at specified intervals and files and duplicates according to instructions

RESPONSIBILITIES OF CASE MANAGER

1. Reviews schedule and signs parent form letter

2. Serves as contact person for parent and child during the evaluations. If possible, greets parent when entering clinic initially

3. Conducts team and parent conferences

4. Sees that parents sign release forms for sending reports to:

   a) Private medical doctor and other professionals
   b) Special placement or private school (to get a progress report from program where child is placed)

5. If case is to be referred to Preschool Admissions and Review Committee, gives parents the application forms and informs secretaries immediately following parent conference so that reports can be forwarded with dispatch

6. Completes interpretive summary and sends to parents within two weeks

7. Completes appropriate sections of Evaluation Record Summary as follows:

   a) Service to family
   b) Cause of problems
   c) Area of greatest need
   d) Placement recommendation
   e) Other placement preferred

8. Circles reports to be sent and records where they are to go according to releases signed

9. Contacts family six weeks after parent conference to determine status and makes the appropriate notation on the Consultation Sheet - Progress Notes in the case folder (Preface notation with "Followup contact".)

SECTION IV: PROFESSIONAL ROLES IN ASSESSMENT

Preface

Section IV delineates the professional roles and functions involved in the DESC assessment. Each professional discipline participating in the DESC Assessment Model describes its basic function and responsibilities and estimates the time required to accomplish these.

AUDIOLOGIST

A. Professional Role in Assessment

1. Rules out hearing loss as a main factor in the delayed development of speech and language skills and overall cognitive development. Before a valid psychological, educational diagnostic, and speech and language assessment can be done, the degree of hearing acuity must be ascertained.

2. Defines the extent of hearing loss, if present, and also makes a determination of the type of hearing loss (conductive, mixed, sensorineural, central auditory processing problem, retrocochlear problem). An appropriate treatment plan is then recommended which may include referral for medical treatment, monitoring of the progressive nature of the loss, fitting with amplification, speech reading and other rehabilitative auditory training procedures, placement in a program for the educationally deaf, etc.

3. Reviews findings at the team case conference and then directly with the parents if it has been determined that the child has a significant hearing loss requiring treatment. The audiologist attends the team conference only if functioning as case manager or if interpreting significant hearing loss to the team and the parents.

4. Serves as a case manager for children whose presenting problem is a communication disability.

B. Time Required

Evaluation - 1½ hour (if difficult to test 2½ hours because 2 audiologists evaluate)

Preconference - 0 (speech pathologist interprets)

Parent conference - 0 (speech pathologist interprets)

Case Manager - 3 hours (if case manager must attend above conferences)

Follow-up - 0-4 hours

EDUCATIONAL DIAGNOSTICIAN/TEACHER SPECIALIST

A. Professional Role in Assessment

The educational diagnostician administers, interprets, and writes individual developmental evaluations and individual educational management plans for preschool children with developmental delays and plans and teaches a short-term diagnostic nursery for children whose problems are more involved, require more time for evaluation, or need screening for appropriateness of a DESC evaluation.

The educational diagnostician assesses the educational needs of the child in relation to his/her developmental level and ability to work within established limits in a stimulating nursery environment. The assessment profile is presented at the team conference and an Educational Management Plan is developed so as to attain appropriate programming. The educational diagnostician also assists in planning and management of overall project operation and maintains community contact for dissemination of project information.

Duties and Responsibilities

1. Performs individual developmental evaluations
2. Conducts and/or participates in team preconferences and parent conferences
3. Writes educational management plans incorporating each team member's recommendations
4. Develops, plans, and teaches a diagnostic nursery class on site
5. Writes individual educational strategies for children in nursery
6. Writes progress reports on children seen in nursery
7. Discusses the program intent, progress, and strategies with parents of children in nursery
8. Demonstrates intervention techniques to be used in the home while child is in nursery
9. Interprets DESC findings and assists in establishing an IEP for DESC cases after placement
10. Presents DESC cases at various levels of public school screening/placement review meetings where deemed necessary
11. Participates in administrative and advisory committee meetings
12. Acts as liaison between DESC parents and public school system
13. Acts as parent advocate for family as they secure placement or when their child attends the diagnostic nursery
14. Acts as case manager on assigned cases and makes followup contacts with parents to check child's progress and parents' needs
15. Acts as liaison between DESC clinic and various program operators
16. Follows up with program providers, when necessary, to assist in further programming for DESC child
17. Assists in planning and management of overall project operation
18. Maintains community contact for dissemination of project information

B. Time Required

Evaluation - 5 hours

Preconference - 1 hour

Parent conference - 1 hour

Case Manager - 1-2 hours

School Liaison - 0-12 hours

Diagnostic Nursery - 1-4 children attend 2½ hours, 3 times a week for 3-6 weeks

1-3 hours prep time is required for each session

NURSE COORDINATOR

A. Professional Role in Assessment

1. Collaborates with the project directors and assumes responsibility for the overall coordination of the services portion of the project.

2. Makes a determination for acceptance of the referral based on history taking and the established criteria guide.

3. Presents those questionable cases for which additional professional opinions are needed at the team conference in order to elicit a team decision for acceptance or non-acceptance.

4. Introduces the family to the DESC system.

5. Collects background information in the form of a "Core History." This detailed information is vital to the diagnostic team whose focus is to identify the problem areas and integrate a solution.

6. Participates in every team conference and coordinates any necessary follow-up with the case manager.

B. Time Required

Evaluation - The time required for taking the Core History is approximately 3/4 - 2 hours, depending on whether the history is taken via telephone interview, office or home visit. Scheduling, assigning a case manager, sending for previous evaluation reports, and setting up the record in conjunction with the secretarial staff takes 1-2 hours.

Preconference - 1 hour

Parent conference - 1 hour (if attended)

Case Manager - 1-2 hours

Follow-up - 0-3 hours

PEDIATRICIAN

A. Professional Role in Assessment

1. Reviews the past medical records, any past developmental evaluations, and the Core History.

2. Completes history of present illness and reviews past medical problems.

3. Defines as completely as possible any factors which might account for the child's presenting problem.

4. Completes the pediatric history with a nutritional history and a review of systems to better define any health factors which may prevent the child from performing at his optimum potential.

5. Performs a complete physical and neurological examination to further delineate any health problems and get an impression of the child as he performs compared to other children his age and to the functioning level of his family.

6. Determines and arranges for laboratory tests and medical referrals to be done on the child.

7. Coordinates any medical follow-up that must be done with the child's private physician.

The pediatrician must determine the aspects of the history and the physical examination which are <u>not</u> pertinent to the presenting problem as well as the laboratory tests results which are <u>not</u> necessary so that the parents may be reassured about these things at the conference if necessary. The pediatrician also deletes from the pediatric evaluation the following usually done in an evaluation for developmental delays: a) a social history leading to a clear understanding of family function and b) a complete developmental evaluation except in areas necessary to complete a neurological examination.

B. Role in Relation to Evaluation Team

1. Interprets the possible importance of medical history to the performance of the child.

2. Suggests further areas for medical investigation and remediation.

3. Refers family for genetic counseling if indicated.

C. Time Required

Evaluation - 2 hours

Preconference - 1 hour

Parent conference - 1 hour

Case Manager - 1 hour

Medical follow-up - 0-8 hours

PSYCHIATRIC SOCIAL WORKER

A. Professional Role in Assessment

The psychiatric social worker, whose primary responsibility is to assess the child's family system, functions as a member of an interdisciplinary team. Roles included are the following:

1. Functions as a member of an interdisciplinary team composed of pediatrician, speech and language pathologist, audiologist, educational diagnostician, nurse, and psychologist.

2. Completes family social history.

3. Interprets significant findings at preteam and parent conferences.

4. Serves as case manager when designated.

5. Provides short-term mental health intervention when appropriate.

B. Time Required:

Family History Assessment - 3.0 hours

Preconference - 1.0 hours

Parent conference - 1.0 hours

Case Manager - 2.0 - 3.0 hours

Brief Mental Health Intervention - 6.0 hours maximum

PSYCHOLOGIST

A. Professional Role in Assessment

1. Evaluates the child's intellectual, developmental, and emotional functioning. This is usually accomplished through the use of standardized test instruments (i.e., Stanford-Binet) in conjunction with less formal or structured observations of the child, interview with one or both parents and review of pertinent material available on the child.

2. Prepares written report and shares with other members of the DESC team in a collaborative team meeting. This is followed by a parent meeting at which results are interpreted to the parents.

3. Provides limited psychological counseling to the parents if necessary.

4. Serves as case manager as required.

B. Time Required

Evaluation - 4 hours

Preconference - 1 hour

Parent conference - 1 hour

Case Manager - 1-2 hours

Counseling - 4-8 hours (if done)

SPEECH PATHOLOGIST

A. Professional Role in Assessment

1. Assesses the child's developmental level in speech and language acquisition using a variety of speech and language standardized tests, speech/language developmental checklist guidelines, and informal assessment techniques.

   This is essential since a prerequisite to skills in reading and writing is the development of verbal communication skills (displaying ability to understand, organize, and use language effectively for communication). The aforementioned kinds of assessment are utilized to obtain the most comprehensive interpretation of the child's speech and language development including receptive and/or expressive language, articulation voice, pitch, and rhythmical speech and his need for treatment if that is indicatee on the basis of the evaluation.

2. Works in collaboration with other members of the DESC team for overall coordination of services.

3. Serves as case manager when assigned.

B. Time Required

   Evaluation - 3 hours

   Preconference - 1 hour

   Parent conference - 1 hour

   Case Manager - 1-2 hours

SECTION V: Preface

The Developmental Evaluation Services for Children, as it is now functioning in Montgomery County, provides a comprehensive evaluation of children, under the age of five, suspected of having developmental delays. The staff realizes that funding for such a comprehensive evaluation could be difficult; therefore, we have developed some alternatives.

ALTERNATIVE STAFF OPTIONS FOR THE DESC MODEL

Three main elements in the DESC model are 1) the coordinator, 2) the medical evaluator, and 3) the educational diagnostician. Furthermore, accurate clerical work is essential. If team members cannot themselves handle the basic recording, correspondence, and filing, then a part- or full-time position must be included in the budget.

Because preschool children with developmental problems often have difficulties with speech and language, a speech pathologist is a highly desirable member of the basic team. The speech pathologist should be experienced in working with preschool children, both as an evaluator and as a therapist. The speech pathologist should be able to communicate with parents and write Individual Educational Plans for children with language needs and should act as consultant to classroom teachers who do not have immediate access to speech pathologists.

Specialists available for consultation should include a speech pathologist (if not a member of the basic team), audiologist, psychologist, physical therapist, occupational therapist, and social worker. Medical specialists should include neurologist, ophthalmologist, otolaryngologist, orthopedist, geneticist, and a psychiatrist.

All team members and consulting specialists should have experience evaluating young children, counseling their parents, and working with their teachers. They should be flexible in prescribing home and nursery school stimulation programs for children whose problems are not significant enough to require special services and allow them to be mainstreamed.

THE COORDINATOR

The coordinator may come from a variety of backgrounds. The most important attributes for this position are a warm personality and an ability to relate to children and their families and to work as part of the interdisciplinary team. Financial considerations and availability of personnel might shape the decision as to what background the coordinator should have.

One option for coordinator is someone with clerical-managerial skills. This person would do the clerical work as well as:

Record basic intake data, make some intake decisions
Obtain basic health and social history from the family using a parent checklist
Collect school and medical records (guided by medical and educational evaluator)

Screen for vision and hearing deficits (with training and under supervision)
Arrange for case follow-through after evaluation completed

Under this option, the educator and medical evaluator would need to review the intake data. They would probably take full responsibility for case management, and they would convey specific information to the center where the child is placed after evaluation.

Another option for coordinator is a nurse with community health, psychiatric, or pediatric nurse practitioner background. This nurse specialist would then:

Record intake data and make most intake decisions
Take basic health and social histories
Collect school and medical reports
Act as case manager
Screen for vision and hearing deficits (with training)
Handle follow-up activities especially those involving health needs

A psychiatric nurse could emphasize the social history. A pediatric nurse practitioner could do the complete medical history and physical examination. (This would require a physician's presence on site at the time of the evaluation to review the case and confirm findings.)

A third option for coordinator is a person with a background in social work (MSW not necessary). This person would:

Record intake data
Obtain basic health information and obtain a strong social work history
Collect school and medical reports (guided by medical and educational evaluators)
Act as case manager in many instances
Screen for vision and hearing deficits (with training and supervision)
Handle follow-up activities especially those involving family counseling

A fourth option for coordinator would be one with an educational background and a firm relationship with the local school system, preferably supervised by the Local Education Agency (LEA). This person could be a teacher, counselor, or pupil personnel worker who would:

Record intake data, make many intake decisions
Obtain basic health and social histories (with training)
Collect school and medical reports (with guidance from medical and educational evaluators)
Act as case manager
Screen for vision and hearing deficits (with training and supervision)
Handle follow-up activities especially those involving educational needs

THE MEDICAL EVALUATOR

The medical evaluator could be a pediatrician or a pediatric nurse practitioner with a pediatrician available for consultation. The evaluator should have a background in early childhood development with experience in working with an interdisciplinary team. Also experience in consulting with

nursery school and day care center staff would be helpful. The evaluator should link the team with the private physicians. If close communication is maintained by the medical evaluator, interpretation of past medical history could be strengthened; private pediatricians could better understand the evaluation and help the parent accept the team's findings and recommendations.

THE EDUCATIONAL DIAGNOSTICIAN

The educator should be a teacher specialist or diagnostic/prescriptive teacher with experience in early childhood development. The educator should have firm connections with the local education agency, preferably be employed and supervised by them, and maintain a close communication to facilitate placement. This specialist should have an up-to-date knowledge of educational programs available within the community, both public and private.

OTHER MEMBERS OR CONSULTANTS

The AUDIOLOGIST is important in evaluating children unable to respond to the hearing screening test. Hearing deficits are a frequent problem in preschool children and can interfere with learning. Early identification and treatment of hearing impaired children is important for their education; therefore, audiological services are essential.

PHYSICAL AND OCCUPATIONAL THERAPISTS are valuable members of the team. Many children with developmental disabilities are clumsy or have neuromuscular deficits which can be precisely evaluated by the physical or occupational therapist. The therapist, in consultation with the medical evaluator, can recommend home plans for children to improve their coordination as well as their self-esteem.

A PSYCHOLOGIST is helpful when emotional problems or questions of intellectual development arise during an evaluation. Some placements require an intelligence quotient for admission; but more often, levels of functioning, as measured by an educational diagnostician, are sufficient. A psychologist who is experienced in dealing with preschool children can be very helpful in expanding the team's understanding of the child's emotional and intellectual functioning.

A SOCIAL WORKER with a background in counseling is a very helpful member of the team. A complete social history often provides psychosocial clues concerning the child's level of functioning and gives a better basis for making a realistic plan for the child. Often details in the past history of the family or attitudes held by family members may make certain placements and plans difficult. Short-term counseling is often important to a family who is coming to grips with the needs of a child with developmental delays. Often counseling around the problems of a particular child can lead to a counseling program for the whole family. Some families do not seek out counseling when it is at an unfamiliar location. A social worker/counselor who has met the family during the evaluation process can ease the strain for such families and help them accept counseling.

Other MEDICAL SPECIALISTS are important in the evaluation of some patients. The PSYCHIATIRST, in particular, can be helpful in evaluating mental health problems within the family and facilitating their follow-up as well as evaluating the personality structure of the child. The

OTOLARYNGOLOGIST is important to children with hearing disabilities and can plan for their long-term remediation in many cases. The NEUROLOGIST provides an important evaluation for the child who has specific neurological signs or evidence of a progressive neurological disease. The OPTHALMOLOGIST provides diagnosis and often remediation for children with eye problems and some generalized diseases. The ORTHOPEDIC SURGEON provides evaluation and prescriptions for orthopedically and neuromuscularly impaired children. The GENETICIST can provide diagnostic tools and his specific acumen in diagnosing inherited disease. The geneticist can counsel parents about future pregnancies.

Although each of these consultants can make a unique contribution to evaluating children, none is essential to the evaluation of all children. The characteristics of the population served, availability of these specialists, and funds will determine how a community chooses to develop their evaluation services.

MONTGOMERY COUNTY PUBLIC SCHOOLS
MONTGOMERY COUNTY HEALTH DEPARTMENT
Rockville, Maryland

APPENDIX

DESC
DEVELOPMENTAL EVALUATION SERVICES FOR CHILDREN
Evaluation Record Summary

Section VI

NAME _____ BD _____ DATE _____

ADDRESS _____

MCPS AREA ____ MCPS HOME SCHOOL _____ MCHD AREA _____

AGE _____ SEX _____ RACE _____ PMD _____ PH _____
yrs. mos.

CALLER _____ PH _____

REFERRAL SOURCE _____ PH _____ _____
NAME PROFESSION AND/OR AGENCY

FAMILY: FATHER _____ BD _____ PH(H) _____ (W) _____

MOTHER _____ BD _____ PH(H) _____ (W) _____

SIBLINGS 1 _____ BD _____ 3 _____ BD _____

2 _____ BD _____ 4 _____ BD _____

PRESENT PLACEMENT STATUS _____ PH _____

REFERRAL REASON (Check all that apply. Circle the check that indicates primary reason.)

____General developmental delay _____
____Specific developmental delay _____
____Hearing, language, speech _____
____Neurological problem _____
____Specific other physical handicap _____
____Emotional, behavioral _____
____Other _____

COMMENTS:

CASE DISPOSITION

DATE _____ COORDINATOR ____ TEAM ____ ACCEPT ____ REJECT ____

REASON _____

CASE MGR _____ CASE CONF DATE _____

SERVICE TO FAMILY

____Literature
____Demonstration
____Home visit
____Counseling
____Referral (specify) _____
____Other (specify) _____

APPOINTMENTS

Nursing _____ Hearing ____ Diag. Nursery _____ Other _____
Vision _____ Speech ____ Case Conference _____ _____
Pediatric ____ Ed DX _____ Parent Conference ____ _____
Social HX ___ Psych _____ _____

CAUSE OF PROBLEMS (Check all that apply. Circle the check that indicates primary cause.)

___Acquired CNS trauma or disease
___Chromosomal abnormalities
___Congenital blindness
___Congenital neurological abnormalities
___Multiple congenital abnormalities
___Prenatal infection or insult
___Perinatal infection or insult
___Unknown
___Other (specify)_____

PRIMARY HANDICAPPING CONDITION _____

CODES _____ _____
Primary Secondary

AREAS OF GREATEST NEED (Check all that apply. Circle the check that indicates area of greatest need.)

___Speech and language intervention
___Specific learning intervention
___Total developmental intervention
___Physical therapy
___Specialized medical services
___Mental health counseling
___Hearing and associated communication intervention
___Appropriate parent education
___No services needed
___Other

DESC PLACEMENT RECOMMENDATION _____

INDICATE IF OTHER PLACEMENT OR TREATMENT WAS PREFERRED, BUT NOT RECOMMENDED, AND WHY.

REPORTS	SENT TO:	DATE
CS PED H S&L ED PSY SOC		
CS PED H S&L ED PSY SOC		
CS PED H S&L ED PSY SOC		
CS PED H S&L ED PSY SOC		
CS PED H S&L ED PSY SOC		
CS PED H S&L ED PSY SOC		

AGENCY ACTION _____ _____ _____
DATE AGENCY ACTION

PLACEMENT _____ _____
DATE PROGRAM

FOLLOW-UP
CONSULTATIONS (Include travel time if significant)
Initial interpretation to program operator
Date_____Hours_____

Follow-up consultations to program operator
Date_____Hours_____Phone_____Visit_____

Date_____Hours_____Phone_____Visit_____

PROGRESS REPORTS

	YEAR I INITIAL	YEAR I INTERIM	YEAR I YEAR END	YEAR II YEAR END
Date				
Program				
Ratings				

WORKSHEET

(To be discarded following completion of assessments)

Please note pertinent findings that may help successive evaluators as child goes through the assessment.

SOCIAL:

MEDICAL:

AUDIOLOGICAL:

LANGUAGE-SPEECH:

PSYCHOLOGICAL:

EDUCATIONAL DIAGNOSTIC:

BV: jb
9/8/78

MONTGOMERY COUNTY HEALTH DEPARTMENT
DESC

Page_____

CONSULTATION REPORTS

Name_____

	DATE	HOURS	

DATE	HOURS	

MONTGOMERY COUNTY HEALTH DEPARTMENT
Rockville, Maryland

Firmly and Legibly *PRINT* all entries. Instructions on Back.

Part A. INFORMATION REQUEST/TRANSMITTAL

TO: .....
.....
.....
.....

RE: Client's Name _____
Other Name(s) Used _____
Date of Birth _____ Sex F M
Address _____
_____
Previous Address _____
_____
Parent(s) Name _____

☐ Please send us the following information on the client named above, in accord with the permission executed below: (MCHD keep copy)

☐ We hereby send you the following information on the client named above, in accord with the permission executed below: (MCHD keep original)

☐ We hereby transmit the following information on the client named above, in accord with your request and permission received: (MCHD keep copy)

(State specific information requested *and* purpose or need for this information) (See instruction 4) _____
_____
_____
_____
_____
_____
_____
_____

Send information to:
Name .....
(Full)
Address .....
.....
.....

Sincerely yours,

Signed _____
Title _____
Date _____

Part B. CONSENT TO RELEASE INFORMATION

I hereby give permission to _____
to release the information specified above for the purpose or need specified above, to _____
_____ concerning the client named above.
Unless specifically stated otherwise in Part A above, this consent expires upon delivery of the requested material, or upon stopping of treatment or of service, or one year from the date signed, whichever occurs first. I understand that this consent also may be revoked, in writing, at any time before material has been requested from others or has been disclosed by the Health Department.

Signed _____ Client named above
Signed _____ Parent or legal guardian
Signed _____ Witness
Date _____

THIS FORM COMPLIES WITH FEDERAL REGULATIONS 42 CFR PART 2 FOR DISCLOSURE WITH CLIENT'S WRITTEN CONSENT

MCHD 2007 (8/77) – INFORMATION REQUEST/TRANSMITTAL AND CONSENT (Supersedes PHN 7)

Instructions for Use of the

Information Request/Transmittal and Release Form

This is a multi-purpose form to obtain Permission to Release Information, and to request or transmit authorized information.

When using this form, the following should be observed:

1. PRINT FIRMLY AND LEGIBLY to insure a good carbon copy.
2. When pertinent, give other names used (maiden names, previous family names, foster names, etc.) and previous addresses of which you are aware.
3. When used as a "transmittal letter" (column 3), there is no need to have the release section signed.
4. To insure that the individual gives *informed* consent *before* the release (Part B) is signed, *all* spaces in Part A *and* Part B must be completed by the employee requesting the information. The following must be written in the appropriate lined spaces and address blocks:
    a. the purpose or need for the disclosure (Part A),
    b. the extent or nature of the information to be disclosed (Part A),
    c. the source and destination of the information (Part A "To" and "Send To" *and* Part B),
    d. requesting employee's signature, title, and date.
5. A witness to the release signature may be Health Department personnel (CHN, clinic nurse, physician, etc.) or, at times when release is sent to a patient's home, it may be another adult in the family.

PLEASE OBSERVE THE INSTRUCTIONS IN THE COLUMNS REGARDING KEEPING THE ORIGINAL, OR A COPY, OF THIS DOCUMENT IN THE PATIENT'S RECORD.

DEVELOPMENTAL EVALUATION SERVICES FOR CHILDREN
12701 Twinbrook Parkway
Rockville, Maryland 20852

CONFERENCE SUMMARY

_____
Name B.D. Age

_____
Parents

_____

_____
Address

_____
Phone

Date: _____

_____ Audiologist
_____ Educational Diagnostician
_____ Pediatrician
_____ Parent/ Guardian
_____ Other

_____ Psychologist
_____ Social Worker
_____ Speech Pathologist
_____ Nurse Coordinator
_____ Other

REASON FOR REFERRAL:

**SUMMARY OF SIGNIFICANT FINDINGS:

Social:

Medical:

Audiologic:

Language-Speech:

*Not Present **Additional information is available from the appropriate professional

Educational Diagnostic:

Psychological:

Relative Strengths:

Relative Weaknesses:

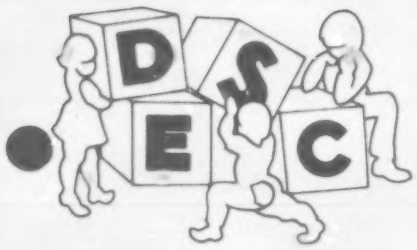
DIAGNOSTIC IMPRESSION:

RECOMMENDATIONS:

EDUCATIONAL MANAGEMENT PLAN:

_____

Case Manager



DEVELOPMENTAL EVALUATION SERVICES FOR CHILDREN
12701 Twinbrook Parkway
Rockville, Maryland 20852
279-1064

MONTGOMERY COUNTY HEALTH DEPARTMENT
MONTGOMERY COUNTY PUBLIC SCHOOLS

An Interagency Program to Help Young Children

Dear

I will be working with you and your child, on the various evaluations which will be done through Developmental Evaluations Services for Children at the Montgomery County Health Department. A schedule of your appointments is attached. All evaluations and most laboratory tests are done without charge to you.

All of the evaluations will be done at the Montgomery County Health Department at 12701 Twinbrook Parkway, Rockville, Maryland, unless otherwise specified. Report to Room 102 or 106 and you will be directed to the proper personnel. Each appointment takes approximately 1½-2 hours.

A parent/guardian should accompany the child for all appointments and both parents/guardians are urged to come for the social history appointment and the parent conference.

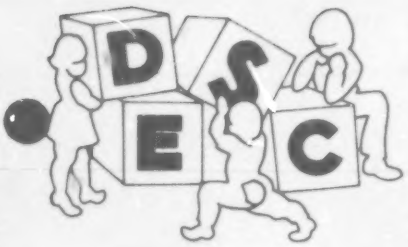
Please call me at if you have any questions, or any changes have to be made.

Sincerely yours,

Case Manager

BV:ch

attachment



DEVELOPMENTAL EVALUATION SERVICES FOR CHILDREN
12701 Twinbrook Parkway
Rockville, Maryland 20852
279-1064

MONTGOMERY COUNTY HEALTH DEPARTMENT
MONTGOMERY COUNTY PUBLIC SCHOOLS

An Interagency Program to Help Young Children

Dear

Enclosed is the DESC schedule of evaluations for

_____, Birth date:_____,

Address:_____.

You are invited to participate in the scheduled team preconference.

Sincerely yours,

Betty Varga, R.N., M.P.H.
DESC Coordinator

Enclosure

BV:ch

DEVELOPMENTAL EVALUATION SERVICES FOR CHILDREN
12701 Twinbrook Parkway
Rockville, Maryland 20852
279–1064

MONTGOMERY COUNTY HEALTH DEPARTMENT
MONTGOMERY COUNTY PUBLIC SCHOOLS

An Interagency Program to Help Young Children

Dear

Enclosed is the DESC summary for _____ b.d. _____.

If you have any questions concerning this report, we would be pleased to hear from you (279-1064).

Sincerely yours,

Case Manager

Enclosure

BV:ch

DEVELOPMENTAL EVALUATION SERVICES FOR CHILDREN
12701 Twinbrook Parkway
Rockville, Maryland 20852
279–1064

MONTGOMERY COUNTY HEALTH DEPARTMENT
MONTGOMERY COUNTY PUBLIC SCHOOLS

An Interagency Program to Help Young Children

Dear

Enclosed is the DESC assessment report for _____
b.d. _____.

If you have any questions concerning this report, we would be pleased to hear from you (279-1064).

Sincerely yours,

Betty Varga, R.N., M.P H.
DESC Coordinator

Enclosure

BV:ch